2003/2004: Report 4

OFFICE OF THE

Auditor General of British Columbia

Alternative Payments to Physicians: A Program in Need of Change

DOC
BC
A9
C
R4:
2003/04:4
2003
c.3

LEGISLATIVE LIBRARY OF BRITISH COLUMBIA
3 3298 00295 0831
104-01850/

2003/2004: Report 7

OFFICE OF THE

Auditor General of British Columbia

Alternative Payments to Physicians: A Program in Need of Change

LEGISLATIVE LIBRARY
VICTORIA BC V8V 1X4 NOV 26 2003

National Library of Canada Cataloguing in Publication Data

British Columbia. Office of the Auditor General.

Alternative payments to physicians : a program in need of change

(Report ; 2003/2004: 4)

ISBN 0 - 7726 - 5093 - 4

1. British Columbia. Alternative Payments Program - Auditing. 2. Physicians - Salaries, etc. - British Columbia. 3. Medical fees - British Columbia. 4. Medical care - British Columbia - Cost control. I. Title. II. Series: British Columbia. Office of the Auditor General. Report ; 2003/2004: 4

R728.5.B74 2003 331.2'816106952'09711 C2003-960254-0

Auditor General
of British Columbia

LOCATION:
8 Bastion Square
Victoria, British Columbia
V8V 1X4

OFFICE HOURS:
Monday to Friday
8:30 a.m. – 4:30 p.m.

TELEPHONE:
250 387-6803
Toll free through Enquiry BC at: 1 800 663-7867
In Vancouver dial 660-2421

FAX: 250 387-1230

E-MAIL: bcauditor@bcauditor.com

WEBSITE:
This report and others are available at our Website, which also contains further information about the Office: http://bcauditor.com

REPRODUCING:
Information presented here is the intellectual property of the Auditor General of British Columbia and is copyright protected in right of the Crown. We invite readers to reproduce any material, asking only that they credit our Office with authorship when any information, results or recommendations are used.

OFFICE OF THE
Auditor General
of British Columbia

8 Bastion Square
Victoria, British Columbia
Canada V8V 1X4
Telephone: 250 387-6803
Facsimile: 250 387-1230
Website: http://bcauditor.com

The Honourable Claude Richmond
Speaker of the Legislative Assembly
Province of British Columbia
Parliament Buildings
Victoria, British Columbia
V8V 1X4

Dear Sir:

I have the honour to transmit herewith to the Legislative Assembly of British Columbia my 2003/2004 Report 4: Alternative Payments to Physicians: A Program in Need of Change.

Wayne Strelioff

Wayne Strelioff, CA
Auditor General

Victoria, British Columbia
November 2003

copy: Mr. E. George MacMinn, Q.C.
Clerk of the Legislative Assembly

Table of Contents

Auditor General's Comments 1

Detailed Report

- Background 9
- External Operating Environment 17
- Strategic alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction 23
- Sound and efficient program operations: the program is undermined by weak management systems 35
- Results-focused program performance: the program is unable to demonstrate what it has achieved 49

Response from the Ministry of Health Services 67

Appendices

- A Summary of Recommendations 79
- B Office of the Auditor General: Risk Auditing Objectives and Methodology . . . 83
- C Office of the Auditor General: 2003/04 Reports Issued to Date 89

Auditor General's Comments

Wayne Strelioff, CA
Auditor General

The people of British Columbia, through their taxes, pay the province's 8,000 physicians over $2.5 billion for health care services. While most of this money is paid through the Medical Services Plan (MSP) billing system, $300 million is paid through a compensation arrangement called the Alternative Payments Program (APP).

Under the MSP billing system, the government pays doctors based on the number of procedures performed for each patient. This method of paying doctors is referred to as a fee-for-service approach.

Under APP, the government pays doctors to provide medical services through service-based contracts, time-based sessional agreements and salary arrangements. Such medical services, for example, are often specialized and labour intensive, or are carried out in training hospitals or in less-populated locations.

All provinces have MSP and APP arrangements for paying physicians (doctors). Deciding how best to compensate doctors is a difficult and often controversial responsibility faced by all governments in Canada. Such decisions involve complicated negotiations and funding agreements. Media attention can be significant, particularly when doctors threaten to withdraw services or when a government threatens to legislate the terms of an agreement.

In this complex environment, the Ministry of Health Services considers APP to be a critical element in the compensation continuum for physicians. It thinks that more doctors should be funded through the program for a number of reasons. First, APP arrangements can help to ensure people have equitable access to medical services. Second, APP arrangements can help to ensure physician services address particular health needs. Third, APP arrangements can help increase accountability by linking the services provided to a predetermined compensation level.

In addition, APP arrangements can be designed to assist the gathering of information on the extent to which physician services contribute to improving patient health outcomes. Such information is a particularly important ingredient to a well-managed, patient focused health care system.

I decided to examine APP management and accountability practices for three key reasons. First, the program is financially significant; the government spends over $300 million a year on this program and expects to spend more in the future. Second, the program is known to be difficult to manage. Third, the ministry asked me to review this program.

Through our review, we examined the extent to which the program is aligned with ministry and overall government direction, the extent to which sound management practices are in place, and the extent to which the money spent and the services provided are linked to the achievement of results.

Overall, we concluded that the program is poorly managed and needs to become much more accountable. In this report, I explain why and offer advice to government on how to manage this program more effectively.

Our findings, conclusions and recommendations are organized into three groupings - strategic alignment, program operations, and results-focused performance.

Strategic alignment

APP lacks clear objectives and effective strategies to ensure the program is aligned with overall ministry direction.

APP does not have a well-understood and articulated strategic direction in terms of program objectives and supporting policies and procedures. As a result, APP is often used as a fix-it mechanism to deal with ad hoc funding pressures. Such pressures often relate to demands by physician groups and health authorities for additional funding that is not contemplated within negotiated funding agreements.

Sound and efficient program operations

APP has weak management support systems.

APP does not have the support systems required for sound and efficient program management. This is particularly worrisome because weak systems have been known to exist for many years. Considerable attention is needed to build the support systems required to properly manage a $300 million program. The systems relate to resource allocation, contract management, staffing and information technology.

Results-focused performance

APP does not have reliable or relevant performance information.

At the program level, APP has not made progress on setting clear performance expectations or gathering information required to determine if the program is successful. Such information includes the extent to which the physician services paid for through this program are improving patient health outcomes in an efficient and effective manner.

My recommendations

In this report, I make 24 recommendations. The following outline some of the key improvements needed. We recommend the ministry should:

- **Develop clear and achievable program objectives for APP that align with the ministry's and government's overall direction.**
- **Develop a comprehensive and publicly accessible policy and procedures manual to ensure consistency in program administration.**
- **Formalize a budgeting process that addresses the program's strategic goals and the continuing need for existing contracts.**

- **Conduct a thorough business analysis based on the future direction of APP before deciding what is required in terms of a staff complement.**
- **Establish formal policies and procedures to ensure services are rendered in accordance with the agreements and all payments have proper approval and are only made for services received.**
- **Develop performance measures that focus APP towards results and ensure these measures contribute to those adopted for the ministry overall.**
- **Put in place ongoing program evaluation that demonstrates how APP adds value to the provincial health care system.**

The development of relevant performance measures and the gathering of the related performance information will be a particularly important challenge. A first step to take is to determine what information is needed and why, how that information can be efficiently gathered and used, and what expectations should be set out within future funding agreements. The people of our province need to know that the services and funding decisions within our health system are focused on how best to improve patient health outcomes.

APP has not been well managed for many years despite the benefit of many internal and external reviews. There is no doubt that the program operates in a complex environment due to the systemic and long-standing issues that exist in determining appropriate physician compensation arrangements. In light of this, some of my recommendations will be particularly difficult to implement or even resisted. But I believe the changes needed for the program are long overdue.

I ask legislators to encourage ministry officials, as well as representatives of health authorities and the physician community to work together to turn this program into an effective and efficient means of delivering health services. All parties involved have an obligation to ensure the program is properly accountable to British Columbians and transparent in its use of taxpayer dollars to the benefit of patients.

I understand the fee-for-service compensation program managed by the ministry through the Medical Services Plan also has significant management and accountability problems. I am now considering how best to include an examination of MSP within my future work program.

While carrying out our examination, we met with many dedicated people who want to make APP an effective component of a well managed health care system. I commend them for their considerable effort.

Wayne K. Strelioff, CA
Auditor General

Victoria, British Columbia
November 2003

❖ ❖ ❖

Review Team

Morris Sydor
Su-Lin Shum
David Lau
Tracy Seddon
Sarah Macdonell
Osami Saito

Advisor

Dr. Charles Wright, Consultant in Medical and Academic Affairs, Program Planning and Evaluation

❖ ❖ ❖

Courtesy: Getty Images

Attending physicians in emergency room

Detailed Report

Background

Purpose and scope of the review

The purpose of this review is to assess the administrative effectiveness and accountability of the Alternative Payments Program (APP) in the Ministry of Health Services. As part of our review, we examined how the program operates, its role in achieving the ministry's vision and how it demonstrates its accountability for results to the ministry and the Legislature.

To determine the strengths and weaknesses of the program, we conducted interviews with ministry executive, program staff, health authority representatives, and other health system representatives. We completed an extensive literature review and cross-jurisdictional research to determine emerging trends and practices in other provinces. Our fieldwork was conducted from November 2002 to May 2003.

Our review was performed in accordance with assurance standards recommended by the Canadian Institute of Chartered Accountants. We included such tests and other procedures as we considered necessary.

We did not undertake a service delivery review as part of this report, for example, an assessment of the quality of the different types of physician services provided through APP. This approach would have broadened the scope of our work substantially and there was concern about the lack of information to be able to complete this type of review. As we consider our work priorities over the next three years, a service delivery review may be an appropriate topic in assessing the Medical Services Plan's fee-for-service system given the dollar size and significance of this program.

Program description

In British Columbia, the Alternative Payments Program began operations in 1968 and was offered as an alternative payment mechanism to the traditional fee-for-service (FFS) model. In the latter, each service has a specific fee associated with it, and the level of income a physician earns relates to the number and types of services he or she provides. In contrast, APP pays health care agencies for a range of services through three main approaches:

- **Service contracts** – contracts for delivery of services between the ministry and health care agencies (service-based payment)

- **Sessional agreements** – standard rates paid for each 3.5 hour session of a physician's time spent on medical services provided through a health care agency (time-based payment)
- **Salary** – fixed compensation paid to health agencies for their employed physicians (employee-based payment).

Alternative payment arrangements were established by the ministry to be used in circumstances where the fee-for-service model alone does not sufficiently support the delivery of physician services or ensure consistent access for patients to necessary health care services. For instance, a fee-for-service arrangement may not give physicians the financial stability they require to provide services in a teaching hospital, a particular community or a hospital-based psychiatric program.

Types of services funded

In British Columbia, APP funds an extensive range of physician services including psychiatry, emergency and community health (Exhibit 1).

Two-thirds of the program's total funding goes towards services that are now delivered through the Provincial Health Services Authority and Vancouver Coastal Health Authority. Some of the program's larger contracts are with the BC Cancer Agency ($32 million), British Columbia's Children's and Women's Health Centre ($21 million), University of British Columbia ($5.4 million) and Forensic Psychiatric Services Commission ($3.6 million).

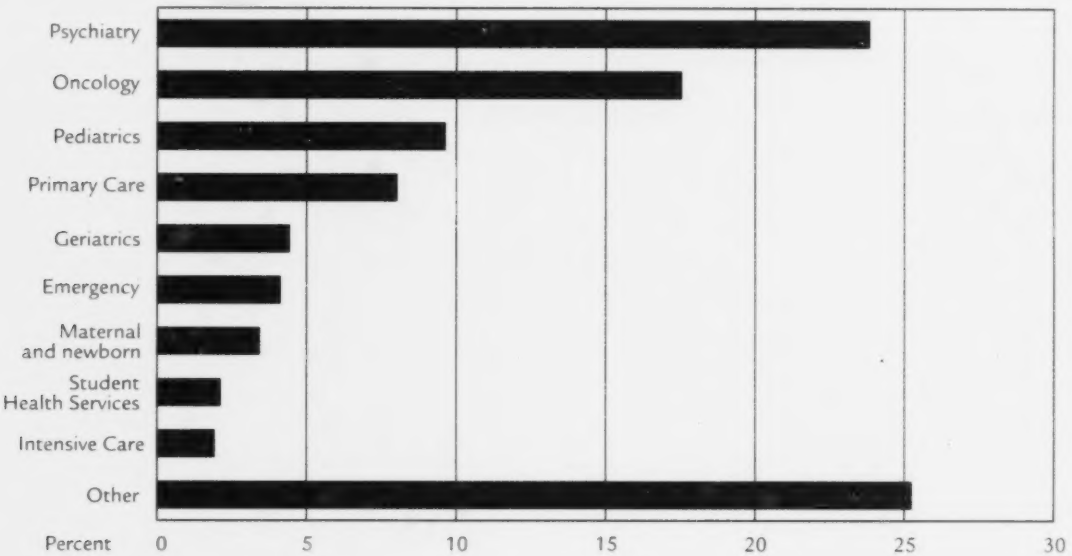
How services are funded

Service-based contracts are the most common type of alternative payment arrangement. These account for approximately 61% of the program's overall expenditures. Under such a service agreement, APP contracts with a health authority or an agency to provide funding for the delivery for physician services. The APP funded health authority or agency then contracts or directly employs individual physicians for the delivery of agreed-upon services.

Time-based sessional payments are another form of alternative payment arrangement. These make up 34% of the APP budget. Under a sessional arrangement, APP provides funding to a health authority or an agency, which in turn enters into a personal sessional contract with a physician for the delivery

Exhibit 1

Percentage of APP funding by type of health services



Source: Data provided by the Alternative Payments Program
Note: *Other* includes health services such as anesthesia, pathology or surgical specialties.

of services based on time, rather than a specific service. One session is a unit of physician time equal to 3.5 hours of service. This method of payment is often used for doctors working in mental health, palliative care, geriatric assessment, and certain kinds of administrative work.

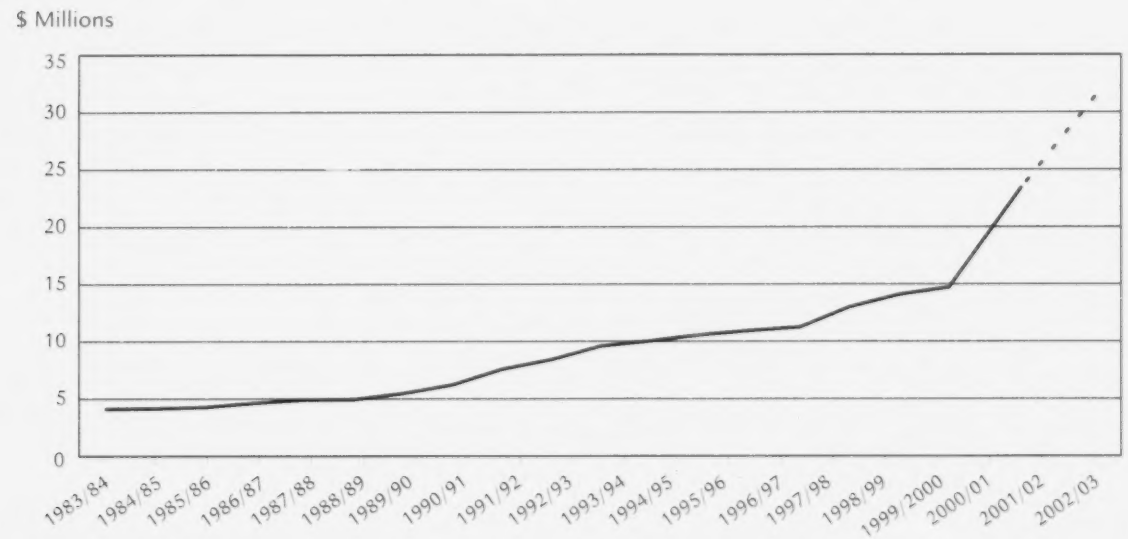
The third form of alternative payment is the salary arrangement. Physicians are hired by an agency on a salary specified by an agreement. Currently, approximately 5% of APP's budget is devoted to salaried payments.

Funding/Expenditures

In 2002/03, 2,250 physicians were funded by alternative payment arrangements (under which they received some or all of their income), primarily through the six health authorities. Exhibit 2 shows how expenditures over the last 20 years have continued to increase.

Exhibit 2

Alternative Payments Program Expenditures, 1983/84 – 2002/03



(Note: For consistency with prior year figures, the dotted line represents the initial budget for 2002/03, although reallocations occurred during the year altering actual expenditures.)

The spending on this program has grown steadily with significant increases during the last two years (prior to funding reallocations last year)—62% in 2001/02 and 33% projected for 2002/03.

Cross-jurisdictional comparison of alternative payment programs

All provinces and territories have a form of alternative payment program, although fee-for-service continues to be the dominant form of payment across the country. According to a 2003 Canadian Institute of Health Information (CIHI) report on Health Care in Canada, alternative payments in 2001 accounted for $1.3 billion in compensation, about 11% of the total amount paid to doctors. Exhibit 3 shows a jurisdictional breakdown of these expenditures by percentage.

Exhibit 3

Percentage of total funding paid to physicians under Alternative Payment Plans across Canada

Source: Health Care in Canada. Canadian Institute for Health Information, 2003

7.8%
1.0%
6.0%
6.0%
5.1%
16.7%
1.8%
8.6%
14.0%

Alberta and Quebec have indicated their intentions to increase the amount of alternative payments to physicians. In the *2002 Alberta Government's Response to the Manzankowski Report* it states Alberta's target is "to have 50% of physicians moving into alternative payment plans, such as rosters, contracts or salaries, by 2005." In July 2002, Quebec announced a proposal to make alternative payments mandatory for all doctors by requiring them to sign service contracts through hospitals or regional health boards. This proposal has yet to be implemented. In Ontario, alternate funding plans for Academic Health Science Centres received new base funding of $75 million dollars in its 2000 budget.

Rationale for our review

Several operational reviews of the program have been conducted over the past 10 years. All of the reviews found that APP is operating with significant difficulty and lacks many elements necessary for a well run program. The ministry has recognized these difficulties and acknowledged that a major restructuring of the program is needed.

In addition to the restructuring, the ministry has stated that it wants to see greater growth in the number of physicians enrolled in APP and that responsibility for program administration may be transferred to health authorities.

We considered these issues and decided there were two main reasons to conduct a review at this time. First, we thought the size of the program—$317 million budgeted in 2002/03—combined with significant growth potential merits attention. And second, while operational issues are a concern, more fundamental questions about the strategic direction and accountability of the program needed to be considered.

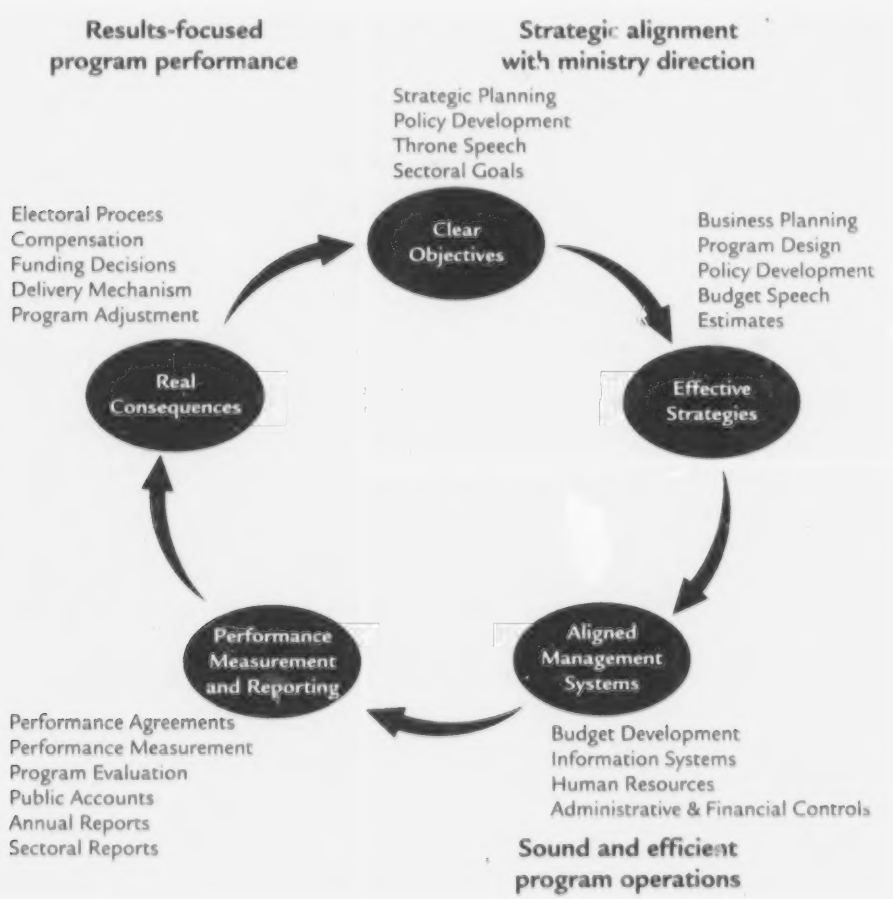
Our primary objectives in taking on this review were to alert legislators and the public to the key issues surrounding APP, and to help promote positive change for the program. We focused our review and recommendations on program management activities that are expected to continue in anticipation that significant changes (such as devolution to the health authorities) may be made to the program.

To guide our assessment, we used the performance management framework developed jointly by the OAG and Deputy Ministers' Council in 1996 (Exhibit 4). We assessed the accountability of APP using this framework under three sets of criteria:

- strategic alignment with ministry direction;
- sound and efficient program operations; and
- results-focused program performance.

Exhibit 4

Performance management framework



Source: *Enhancing Accountability for Performance in the British Columbia Public Sector*, joint report of the Office of the Auditor General and the Deputy Ministers' Council, April 1996

To assess strategic alignment, we reviewed whether APP had clear objectives and effective strategies in place. For program operations, we examined whether the systems and activities set up to manage the program were sound and efficient. On program performance, we assessed whether the structures and processes in place to measure and report on performance were appropriate, and how all these issues resulted in real consequences for the program.

During the program's 35 years of operation, it has become apparent that many factors affect how it is managed. Among the most relevant of those are the:

- availability of physicians
- complexity of negotiating physician compensation
- accountability for physician services
- growth potential of APP

We describe each of those factors here as they set the context for our findings and recommendations.

Availability of physicians

The availability of physicians has been a much discussed topic in recent years. The Canadian Institute for Health Information (CIHI) provides data on their website for Health Human Resources on the number of physicians per 100,000 population by province/territory in Canada. Based on this comparison, Exhibit 5 indicates that B.C. has the third highest number of physicians, after Quebec and Nova Scotia. However, these figures alone are not sufficient to assess the availability of physicians.

Exhibit 5

Number of Physicians per 100,000 Population by Province/Territory, Canada, 1997 to 2001

	Total Physicians					
	1997	1998	1999	2000	2001	% change (97-01)
Nfld.	169	170	171	172	177	4.7
P.E.I.	121	127	130	128	137	13.4
N.S.	188	195	199	201	200	6.1
N.B.	149	153	154	152	156	4.4
Que.	209	211	212	214	214	2.1
Ont.	179	179	179	180	180	0.8
Man.	177	177	179	181	182	3.1
Sask.	144	149	153	154	153	6.3
Alta.	157	162	167	166	167	6.1
B.C.	191	193	193	195	197	3.2
Y.T.	157	145	133	136	182	16.0
N.W.T.	98	92	127	112	92	(6.0)
Nun.			40	25	24	n/a
Canada	183	185	186	187	188	2

Source: Canadian Institute for Health Information Website, Health Human Resources – Physicians, 2003

Many reviews and studies have tried to determine whether there is a shortage or surplus of physicians. In June 2002, CIHI released the report *From Perceived Surplus to Perceived Shortage.* This report outlines that during the 1990s, the concern was that physician supply was growing faster than needed by the growth in population. The CIHI report indicates a different view has now emerged and that there is a *relative shortage* of physicians, as implied by the 5.1% decrease in the physician-population ratio from 1993 to 2000. However, it also makes the point that the year 2000 ratio is at the same level as in 1987. Thus while CIHI suggests there is a growing consensus of a physician shortage, it does not declare an absolute shortage.

There are certainly many divergent views on this issue. Some people believe the distribution of physician supply is what needs to be addressed. Others suggest that more nurse practitioners, physician assistants and related health care professionals are required, rather than doctors. Still others believe that information technology should be used by physicians to help manage their workload.

It is beyond the scope of this review to determine whether there really is a shortage of physicians. However, we do think it is fair to point out that perceptions on this issue play a significant role in how APP is managed. The program is often used to fund physician services when the ministry believes doctors are in short supply, either in a specific location or for specific services (e.g. thoracic surgery). In our report, we do examine the "crisis" nature created by this perception, and how that affects the program.

Complexity of negotiating physician compensation

Staff of APP negotiate specific service agreements (contracts) with health authorities, and in the past directly with service agencies. However, the majority of physician-related negotiations occur outside of APP and result in three levels of agreements made between the government, the Medical Services Commission (MSC) and the British Columbia Medical Association (BCMA). These are shown in Exhibit 6. Negotiation of these agreements focuses primarily on the fee-for-service system. However, there are many APP specific issues that are contained within the Subsidiary Agreements, for example, service rates, a contract template and provisions related to retention of records.

Exhibit 6

Current provincial agreements for physician compensation

Levels of Agreements	Description
Second Master Agreement	Agreement that establishes the framework for negotiation and consultation
Working Agreement	Economic (compensation) agreement between the government and doctors that sets out fees, on-call payments and physician benefits, including disability and malpractice insurance, education funds, retirement plan contributions and maternity leave.
Subsidiary Agreements	Agreements that address matters of unique interest and general applicability related to general practitioners, salaried physicians and physicians providing services through contracts or on a sessional basis and practising in rural areas. There are four types: ▪ provincial salary agreement ▪ provincial service agreement ▪ provincial sessional agreement ▪ rural subsidiary agreement

Source: Ministry of Health Services' Medical Services Plan website

Both the ministry and BCMA acknowledge that these negotiations are very complex, often controversial and highly sensitive to the public and elected officials. Media attention can also be significant, especially when negotiations are stalled and there is threatened withdrawal of physician services.

Negotiations for APP agreements involve similar complexities and controversies but at the community level. For example, the ministry can be faced with physicians considering leaving the province to obtain higher compensation. While we did not examine these types of issues as part of our review, we recognize the tensions and dynamics created by negotiations strongly influence how the program is managed.

Accountability for physician services

The ministry indicates it plans to strengthen accountability over how it makes payments to doctors. Concern was expressed by the ministry that there is actually very little accountability required of physicians in relation to the payments made to them, irrespective of the compensation model used. The ministry wants to ensure that services being funded are actually provided.

In its November 2002 report, *Building on Value: The Future of Healthcare in Canada*, the Romanow Commission stated that:

"Some suggest that future negotiations with physicians should clearly outline the deliverables physicians are expected to provide such as ensuring adequate access to health care services, changing their patterns of practice to facilitate primary health care or to meet changing needs in the health care system or achieving certain outcomes for their patients (e.g., screening for certain tests)."

The current service rates for APP negotiated in the Subsidiary Agreements range from $150,000 for a general practitioner to over $400,000 for a surgical specialist. The ministry has stated that efforts to obtain increased accountability is extremely difficult because of differing views as to what is required. As a result, expected reports on service levels usually become part of the negotiation process. Although, the government negotiated a reporting requirement in November 2002 specifying that physicians must provide equivalent fee-for-service billing information, implementing this requirement continues to be a contentious issue discussed as individual contracts and agreements are negotiated. We discuss this matter further in our report, under Program Performance—Monitoring and Reporting.

Growth potential of APP

The ministry would like to see APP become a larger component of how physicians are paid in British Columbia. It believes APP has significant potential beyond the capabilities of the fee-for-service system to provide more holistic care at a predetermined cost, improve health care services and strengthen accountability. There are many views as to the advantages/disadvantages of each model.

As fee-for-service is based on the number of visits to the physician, some experts suggest that this is a volume-based, process driven approach that can lead to escalating costs and does not promote incentives for health outcomes or promotion/prevention. Another concern with fee-for-service is the inability of the payment system to allow physicians to be responsive to different practice settings, such as in rural areas with small or dispersed populations, or for physicians serving in emergency rooms.

The alternative payment approach can address some of these limitations and offers various opportunities for improving access to health care. For example, the ability to contract for services may provide greater flexibility in paying for physicians in areas where it is difficult to recruit and retain them, or for services that are time intensive.

However, as discussed above, fee-for-service remains the approach used by most doctors in the country. It is a well established and some would suggest, a more efficient method of compensating physicians.

The Romanow Commission suggested that "alternative methods of physician remuneration should be explored...in order to de-link physician income from number of visits." Other studies, however, have evaluated the difference between the two types of programs and did not come to a clear consensus that one is absolutely better than the other.

We did not join this debate in our review. We examined how the ministry is managing the program and whether adequate accountabilities have been built into the system. Without effective administration and accountability, the program will continue to struggle irrespective of its potential benefits.

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

Clear Objectives

Clear objectives are the first element in the performance management framework. The establishment of objectives is key to providing the program with a planned destination.

APP does not have clear objectives to ensure alignment with ministry direction

The ministry has not formally committed to a statement of objectives for APP. Objectives are needed to identify at the outset the purpose of the program. We found there was no collective understanding from a ministry or health authority perspective of why the program exists, aside from being an alternative payment mechanism to compensate physicians.

Without clear objectives it is difficult to determine if APP is in alignment with broader government and ministry direction. This direction provides the strategic outlook needed to inform APP's objectives. For example, the ministry's goals, as described in its service plan, are: high quality patient-centred care, improved health and wellness for British Columbians and a sustainable, affordable public health system. The program needs to have objectives that support these goals.

In an integrated approach the ministry would set out in its service plan those goals and objectives that are in line with government's overall strategic plan. In turn, each program area within the ministry would then identify its role in achieving the broader government and ministry goals and objectives. This relationship is shown in Exhibit 7.

Exhibit 7

Alignment of broader goals and objectives related to APP

Goals/Objectives in Government of BC's Strategic Plan
Goals/Objectives in Ministry of Health Services' Service Plan
Goals/Objectives for Alternative Payments Program

Source: Compiled by the Office of the Auditor General of British Columbia

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

We examined several external and internal documents looking for program objectives. The only statement of objectives we found was contained in an internal document created for the ministry's 2002 Core Review (a government wide initiative to "rethink government and systematically review the businesses of each ministry and government agency). Those objectives were to:

- "Improve access to physician services, particularly in remote and rural areas of the Province;
- Stabilize key provincial referral and tertiary programs in urban centres;
- Support services that are time intensive and require extensive service coordination;
- Encourage a more holistic approach to patient care; and
- Promote prevention and teaching activities."

None of these appear in the two primary documents, the *General Information 1999 and Glossary of Terms* and the *Conditions of Funding*, related to APP. Both documents are intended to provide: a general overview of alternative funding arrangements, circumstances for funding, and procedures for applying to APP. However, several health authorities told us that the guidelines are unsuccessful in communicating the aim of the program.

We recognize that establishing objectives for an alternative payment program can be a challenge. The fact that several other provinces have also not done so could be symptomatic of the difficulties inherent with these types of programs. Our research revealed that only one province, Ontario, has established specific objectives for its alternative payment program.

Ministry executive and program staff have acknowledged that the lack of objectives for APP is a problem, and they indicated over a year ago their intention to change that. However, the process of articulating specific objectives appears to have been delayed because the ministry has been conducting the transition process to implement provisions of the Provincial Service, Salary and Sessional Agreements.

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

During our field work, we asked interviewees what they thought would be good objectives for the program. The themes of providing stable and accessible services and adequately compensating time intensive services were often expressed. Such ideas offer the ministry a starting point in developing objectives. One of the most significant issues for the ministry to sort out will be whether the program should cover all forms of alternative compensation (e.g. including that for on-call and rural incentives) or only a specific type of alternative payment (e.g. primary compensation).

Health authorities also expressed interest in being involved in setting the future direction for APP. They told us they would like to see an increased emphasis on alternative payments being used to assist with recruitment and retention in all areas of the province. Given that the program exists in the context of strong partnerships between the ministry and the health authorities, we believe that the establishment of program objectives should occur in a consultative manner that ensures their alignment with health authority—as well as ministry—direction.

Good guidance in setting clear program goals and objectives is provided by Treasury Board in its *Guidelines for Ministry Service Plans 2003/04 – 2005/06*. According to the guidelines "program objectives should:

- Be phrased as result statements and not as activity statements
- Have clearly stated concrete measurable results
- Answer the following questions: What specific results of the objective is seeking? What is being measured? When can you expect to see results?
- Be adequate in aggregate to achieve their corresponding goals

Recommendation

We recommend the ministry develop clear and achievable program objectives for APP that align with the ministry's and government's overall direction.

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

Effective Strategies

Effective strategies are the second element of the performance management system flowing from clear objectives. Among the key factors that support effective strategies are business planning, policy development and program design.

APP has been operating without a business plan

APP does not operate with a business plan. A business plan is the link between an organization's higher level goals and its functional activities. It lays out how the organization plans to conduct its work and includes:

- strategic context
- goals and objectives
- strategies
- performance measures and targets
- resources required

For APP, we found that business planning has been minimal. Emphasis instead has been on addressing immediate issues. Program staff expressed frustration with the lack of direction from ministry executive and the lack of planning. Time constraints and the inability to dedicate resources to a business planning process were cited as the main reasons.

In 2002, an external consultant was contracted to conduct a business process review of APP. The final report stated that "APP has expanded without strategic direction or a vision." In our view, this lack of planning leaves the program open to many risks. For example, program spending only grows when a crisis arises, such as physicians threatening withdrawal of services. The program responds with a new contract to maintain health care services. As a result, program growth is unmanaged with no connection to an identified strategic direction. With inadequately allocated resources, APP has limited capacity to plan, manage and mitigate risks. No risk management strategy has ever been created. These elements could be comprehensively addressed in a business plan.

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

A business plan is a valuable tool that aims to balance issues regarding capacity with a blueprint for ensuring that adequate resources are available to meet strategies for successful implementation. This can be a simple document that describes the program's plan for the coming one to three years produced as a result of participating in a business planning process. Exhibit 8 illustrates the type of business planning process that we expect the ministry to have considered in managing APP. A similar process should be incorporated into APP.

The government in British Columbia is committed to business planning. The Deputy Ministers' Council stated in a 1997 joint OAG/DM report that "ministries and programs will produce three to five year business plans." And in the *2003/04 – 2005/06 Ministry*

Exhibit 8

Components of a Business Planning Process

Source: Compiled by the Office of the Auditor General of British Columbia

of Health Services Service Plan one of the stated key strategies is to "embed sound business practices and a business management culture within the Ministries of Health." The performance indicator for this strategy is the percentage of divisions having a business plan. This approach should, we believe, cascade down to APP.

We note collaborative business planning processes have been used in other ministry programs, such as that which was established for the rural health and provincial on-call programs.

Recommendation

We recommend the ministry conduct a business planning process in order to establish a well-defined approach for managing APP.

Minimal policy exists to guide use of the program

To run well, a program requires policies and procedures that outline expectations and parameters for program use. Good policies also result in a more common understanding about the program among internal and external stakeholders.

Current provincial agreements for physician compensation do set some policy parameters for the program. However, we found that comprehensive operational policies and procedures for APP do not exist. One of the key ministry policy documents, *General Information 1999 and Glossary of Terms*, offers limited direction and is considered dated by both ministry staff and the health authorities. And with the program's lack of clear objectives, it is difficult to determine whether the limited policy in place even aligns with the ministry and program strategic goals.

Many health authority and ministry staff we interviewed expressed frustration about the lack of consistency in how the program is applied. They said they would like to see the program operating in a functional manner, setting priorities, effecting strategies and adhering to program parameters.

Part of the problem is that program knowledge lies not in one manual, but with different staff members. This results in varying interpretations in policy application and with staff changes or reductions this can erode "existing policy."

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

The ministry has begun drafting policy and procedures, but has not progressed further because it first needs to identify program objectives. A documented operations (policy) manual would bring policies and procedures into one place so that they are consistently applied and accessible. As an example, both the Pharmacare and the Rural Incentive Compensation Program have established comprehensive policies and posted them on the ministry website where they are accessible to all external stakeholders and the public.

Recommendation

We recommend the ministry develop a comprehensive and publicly accessible policy and procedures manual to ensure consistency in program administration.

APP has been used to respond to crises inappropriately

Crisis situations for the ministry and the public can arise when work action is threatened and puts the availability of health services at risk. Under these circumstances, APP has been forced to respond in ways to prevent disruption of service that are outside of apparent policy parameters.

In our view, these circumstances inhibit the program from conducting its normal operations of reviewing and making approvals on applications based on funding criteria. No new applications to APP have been processed in this manner for three years. Health authority and program staff told us that the most expedient way to get an APP application processed is for it to be related to a crisis. Eight new contracts negotiated in the past three years have all circumvented the standard application process. In every case, they were previous applications submitted to APP, but they did not receive approval until being perceived as necessary to address some sort of crisis that could seriously impact access to a health service.

In the past several months, a number of concrete steps have been taken to prevent crisis situations from arising. For example, a province-wide emergency room strategy has been initiated to set stable, consistent direction. This strategy is based on an interim workload to determine appropriate staffing levels for emergency departments. The framework was developed by the Ministry of Health Services with input from the health authorities and the BCMA emergency section.

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

We believe that a standardized response to emerging physician compensation issues should be established in policies and procedures. This would likely reduce the number of unique deals and improve transparency.

How APP is Used in a Crisis Situation

The ministry faces a difficult challenge in dealing with crisis situations where access to services are threatened. The following provides a typical, although fictitious scenario that demonstrates how APP is invoked to deal with the crisis quickly.

For twenty years, a sole general practitioner (GP) has been effectively serving the population of a small rural community. Over this time, the population has been slowly increasing, but with no corresponding increase in physicians. The GP does not feel he/she can continue to see more and more patients without sacrificing quality of care. Furthermore, the GP believes it is time to start slowing down towards retirement.

Efforts were made by the local health authority to recruit a second physician. However, it has proven difficult to attract another physician to this rural setting due to the "small town" lifestyle, and the concern that there will not be a high enough income generated by billings through the fee for service system to support a second full-time physician.

After a year of waiting, the GP withdrew services to draw attention to the need for a second physician. The GP became available for appointments four days a week and on call every third day. This left significant gaps in service delivery and as a result, residents questioned the accessibility to quality health care.

As this situation continued, residents became more panicked and several brought their concerns to local politicians. The community newspaper also ran front page stories reporting on how many patients had to drive for over two hours to the next town in order to receive medical care. The local Mayor contacted the Minister of Health to explain this dire situation.

The Minister asked the Deputy Minister of Health to deal with this crisis situation expediently. The Deputy Minister called the Chief Executive Officer of the local health authority who said the health authority had talked to a physician willing to move to the community, but that the physician wanted a guaranteed stream of income. Both determined that the Alternative Payments Program (APP) could be used in this circumstance. A service contract was quickly drawn up with a negotiated amount of compensation. Due to the immediacy of this situation, and the public attention being received, the application was rushed through, circumventing the normal approval process.

Thus, a crisis situation was resolved through APP, but without the benefit of proper analysis to determine what constituted an appropriate level or type of service for that community, and if the level of funding negotiated provided good value for the taxpayer.

We recognize that these types of crisis situations are not unusual and that the ministry must be able to respond quickly when necessary. However, we are recommending that specific policies and procedures be developed to treat crisis situations in a consistent and fair manner, so that proper analysis can be done to justify the taxpayer dollars being spent to fund the physician's services. Otherwise, the program becomes an ad hoc funding mechanism without the credibility and supports needed to resist using the program inappropriately to "fix" a crisis.

Recommendation

We recommend the ministry establish specific policies and procedures to deal with crises in a consistent manner, as part of a comprehensive policy and procedures manual.

Frequent review and change proposals have resulted in program instability

Several studies or reviews of APP have been carried out during the past 10 years yet none has resulted in any significant changes from a strategic or operational perspective (with the exception of the development of the 1999 *Conditions of Funding* document). As a result, the program is often in a state of flux from either being reviewed or waiting for change.

Among the reviews conducted (before this one):

- 1994/95 MSP review by the Office of the Auditor General
- 1997 – Internal Audit Review by the Ministry of Finance
- 1999 – Two internal reviews by the Ministry of Health
- 2002 – Report by an external consultant

After looking at these previous reports, we concluded operations have changed minimally despite the recommendations and many of the problems continue to exist. A work plan was created in October 2002 as a result of the last consultant's report, but has yet to be implemented. However, the ministry was awaiting preliminary results from our review before proceeding further with program changes.

This constant expectation of change creates an unstable working environment and affects all elements of the program, including staffing, operations and policies. Change often elicits an emotional response in people and can disrupt productivity. Program staff at APP expressed their frustration with the stagnation of the program, the lack of direction and frequent possibility of changes. Health authorities echoed this frustration pointing to the negative effects that APP's constant upheaval has on their relations and expectations.

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

Changes to this program are often not viewed as a priority in light of other competing demands on the fee-for-service system and Pharmacare within the ministry. As well, changes to the program are difficult due to the cost, time involved, program disruption and program complexities.

Nevertheless, we think that the ministry should make changes that will address the existing problems in the program. In doing so, it will be necessary for the ministry to implement changes linked to broader planning and evaluation processes to improve stability and integrity of the program. The key will be ensuring consistency in direction and devoting appropriate time and resources to the program rather than allowing diversions to other priorities or new proposed directions.

Recommendation

We recommend the ministry implement changes linked to broader planning and evaluation processes for APP to reduce the ongoing impact from program instability.

Linkages to other key physician compensation programs and initiatives are inadequate

Several ministry programs and initiatives deal with physician compensation. Some offer core compensation while others offer additional incentives specifically for recruitment and retention. These programs and initiatives include:

- MSP
- Primary Care
- Medical On-call/Availability Program (MOCAP)
- Rural Incentive Compensation Programs
- Rural Specialist Locum Program
- Doctor of the Day
- Benefits
- Clinical Academic Services Contracts (CASCs)

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

- Health Match BC
- HR Recruitment and Retention Strategy for Physicians
- Negotiations

We found that none of these programs are effectively linked and that there is duplication and inconsistency. As well, there is a risk that separate program policies could be counterproductive. Lacking is an overarching framework or policy for determining physician compensation that outlines the different programs and appropriate linkages.

Many health authorities spoke of their confusion in dealing with these various programs to pay physicians, and described the complexity as excessive. Many individuals expressed uncertainty as to whom they should speak with regarding physician compensation.

We noted that APP is often used as a "fix it" program when other programs cannot be used. As such, many APP contracts included components of rural, academic, on-call and primary care programs. With the lack of coordination among program areas, issues are difficult to address.

APP staff have been reviewing existing contracts to separate out different types of compensation and redirect each to the appropriate program for administration. As well, changes are being made to on-call and rural programs to increase their effectiveness. A review of APP is expected to follow and should lead to improved linkages between all programs.

The ministry has also taken an initial step to create an organizational structure to improve coordination. It has now located all programs—primary care, rural, on-call, doctor of the day, clinical academic service contracts and APP in the Medical and Pharmaceutical Division.

However, we emphasize that part of APP's success depends on well formed linkages to other programs. This requires clarifying what each program should achieve and then determining how all of them can work together. Such a step will be key in enabling the ministry to properly define APP's direction, and also to assess the program's impacts on other areas of the ministry.

Strategic Alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction

Recommendation

We recommend the ministry improve the coordination and effectiveness of all its individual compensation programs by establishing an overarching physician compensation framework that outlines each program and illustrates program linkages.

Sound and efficient program operations: the program is undermined by weak management systems

Aligned Management Systems

The third element in the government's performance management framework expects that management systems for a program will align with the program's long-term strategic direction and be consistent with ministry goals and objectives. For this to occur, the program should be supported by an appropriate budgeting and funding allocation process, adequate resourcing, an effective contract management process and adequate information technology.

Budgeting and Funding Allocation

The annual budgeting process focuses on incremental components and fails to link budgeted resources to strategic program directions

Because the annual budget decisions for APP are not linked to clearly defined objectives or results (since these have not been established), the program's ability to manage growth and allocate resources effectively is seriously limited. Furthermore, the program's focus on incremental budgeting makes it difficult to identify deliverables, develop performance measures and monitor the results. Even when the annual budget is set, the program funding could be transferred to other programs. This lack of strategic focus is limiting the program's ability to manage and meet its intended objectives.

In general, the APP budgeting process has always centred on allocating the incremental components for new commitments. At one time, the process included consultation with health authorities and funded agencies to assess their needs and priorities. In recent years that changed and the process became based on the prior year's budget or experience of actual funding for agreements, and adjusted for cost pressure, known new contract commitments and funds transferred from and to other programs. No assessment is ever done of base funding for APP to determine the continued need for existing or expired contracts.

We believe that APP's base funding should be reviewed, at least periodically, so that the ministry knows whether its services are cost effective and capable of meeting short- and long-term program needs. Without such an assessment, APP may be funding services that are no longer necessary, appropriate or aligned with objectives.

Recommendation

We recommend the ministry formalize a budgeting process that addresses the program's strategic goals and the continuing need for existing contracts.

The process to transfer funds to APP from the fee-for-service payment model lacks clear policies and guidelines

In accordance with the Second Master Agreement, the ministry can transfer money from the Available Amount (the total annual funding the government provides for fee-for-service compensation) to APP when fee-for-service physicians decide to move to the APP payment model. This transfer is one of the key sources of additional resources for the program. Under the Agreement, the dollar amount of the transfer must be equal to the amount that had been paid to the physician providing the identified services in the 12 months preceding the date they opt to switch payment models. Other than this formula on how to calculate the transfer amount, there are no clear guidelines established to ensure fairness of the amount being transferred under different transfer scenarios. As a result, the calculation of the transfer amount is often a subjective one.

Management of APP has already recognized this problem and formed a Review Committee to oversee transfers from the Available Amount to APP. The committee, made up of three senior staff of the Ministry of Health Services, reviews proposals and prepares recommendations on funding transfers. For example, physicians in Gold River-Tahsis felt that the fee-for-service model did not work well due to the small volume of patients in their rural area. They asked to be transferred to the APP payment method. The committee then worked with the physicians and the health authority to determine the rationale and requirements for an alternative payment arrangement.

We believe this committee works well. Not only does it provide assurance that the funding decisions for transfer services are determined on some basis of sound business analysis, but it promotes transparency in the decision-making process. Nevertheless, given the complexity of many transfer situations, better guidelines are still required to assist the committee in its work.

Recommendation

We recommend the ministry develop detailed policies and guidelines to govern the calculation of transfers from the Available Amount to APP, to ensure consistency and transparency in decision-making.

Human Resources

Staff resources have been significantly reduced without sound analysis or a change plan

As a program driven by contracts, APP is more labour intensive to administer than the fee-for-service payment method. Under the latter, the compensation for each service type is at a fixed rate and the payment process is automated and well established within the ministry. Contract management, on the other hand, requires knowledge in evaluating applications, negotiating appropriate terms, tracking payments and monitoring deliverables. Therefore, APP requires adequate resources and skilled staff.

We found, however, that the ministry's fiscal 2002/03 target for program workforce reductions has significantly affected the APP area. The plan for the program was to reduce the number of staff by at least 50%. This reduction, we learned, has not been supported by a sound business case analysis or a change plan to ensure the program can function effectively. Instead, the staff cutbacks were meant to achieve government-wide targets and were made with little regard for losses in corporate knowledge and functionality. As a result, only a residual concentration of "program memory" and skills still exists, and only in a small number of key personnel.

To cope with staff reductions, priority has been placed on preventing disruption to physician payments. The outcome is that key controls and best practice for contract management are not being followed. For instance, we found evidence of minimal follow-up to ensure that contracted terms and services were fulfilled by physicians and that payments were made only with valid agreements.

Sound and efficient program operations: the program is undermined by weak management systems

The ministry has plans to integrate sessional payments with the MSP payment system to streamline the payment process. At present, the ministry is reviewing different options for how this integration could be carried out. While we understand that this approach could require fewer resources overall, we noted that the ministry has not defined the staff capacity needed for the new direction in terms of resource and skill requirements.

As APP's mandate is under assessment, it is impossible to know whether the current staff skills (following the cutbacks) will be adequate to fulfill the new mandate and manage the program. An analysis of program strategic goals and objectives is needed so that a staffing profile can be established.

Recommendation

We recommend the ministry conduct a thorough business analysis based on the future direction of APP before deciding what is required in terms of a staff complement.

Poor communication has created misunderstandings between ministry and health authorities

We heard frustration among health authorities about the ministry's processing of applications. The time lag and cumbersome nature of the process were frequently specified, but there were also concerns that some program staff lack the necessary background to understand the issues being raised. As a result, the health authorities often turn directly to senior management of the ministry.

At the same time, we also heard frustration expressed by ministry APP staff about the lack of information coming from the health authorities and that health authorities were making arrangements with physicians outside the funding guidelines without approval by APP.

We believe this frustration and misunderstanding between the two groups are mainly the result of unclear expectations by both parties about what APP can accomplish. Adding to the problem is the program's inability to be responsive to change and the ever-increasing demand for services. In our view, such

poor communication is undermining not only the legitimacy and credibility of the program, but the larger efforts by the ministry to stabilize physician services. Effective relationship management requires two-way communication and extensive consultation to meet established objectives. Clarifying the expectations of both groups in a consultative process will increase the likelihood that a sound relationship can be established.

The ministry has taken steps aimed at improving relations with health authorities and increasing consistent direction in the program. It has involved one or more of the health authorities to look at a couple of areas to examine the potential for more coordinated provincial programming and services.

Recommendation

We recommend the ministry improve how it communicates with health authorities to ensure both parties understand each other's expectations.

Lack of stable executive leadership creates uncertainty and inconsistency and impedes program movement

Consistent management direction and leadership is needed to ensure that broad-based objectives are set and pursued. Over the years, APP has not had this. Frequent changes in executive leadership have created uncertainty at many levels and limited APP's growth potential to respond to emerging physician compensation issues.

The high turnover has been evident at both the executive and program levels. The current acting director has had five reporting relationships in the past two years with three assistant deputy ministers and two executive directors. Before that, there were eight directors in four years. The current director has been acting in this position for the last two years. Such constant change hampered the stability of the program at the operational level and, as the 2002 consultant's report noted, "hindered the program's ability to move forward with change." An environment lacking stable leadership and clear direction leaves staff uncertain of intentions for the program.

Sound and efficient program operations: the program is undermined by weak management systems

In a report we published in 2002/03, titled *Building a Strong Work Environment in British Columbia's Public Service: A Key to Delivering Quality Service*, we stated that it is the responsibility of senior leadership to create a common vision and goals for the organization. Strong leadership requires regular communication and reporting between levels of management to assure accurate implementation of the vision. We also noted that "one partial explanation for the lack of clear direction [in the public service] may be the high turnover in the executive ranks."

With ongoing change in leadership, it is essential to ensure that there is an appropriate transitional procedure in place. We recognize that the ministry has taken initial steps to improve the situation. For example, the current assistant deputy minister, who has been in this position for over a year, established an executive director position specifically to create leadership stability for the program. However, in less than a year, two people have held this position. Continuing efforts will be required by the ministry to ensure there is a longer-term stability in the program's senior ranks.

Recommendation

We recommend the ministry commit to creating greater stability in APP's leadership structure so that consistent, clear direction is provided.

Contract Management

Operational management of contracts has been the subject of several program reviews, but only minimal changes have been made to improve the overall effectiveness of the process and systems.

Contracts, if managed properly, can be a useful way for government institutions and agencies to allocate funds to achieve desired goals and to demonstrate accountability for deliverables. It is therefore essential that the contract management process be established based on sound practices. In this section, we focus on four key components for a contract management process: application approval, terms and conditions, tracking and payment, and monitoring and compliance.

The application approval process is backlogged and not demonstrably transparent and fair

Because of the length of time it took to negotiate the last round of provincial agreements with the BCMA and the problems encountered in implementing those agreements, the APP application approval process has not been active since September 2000. However, health authorities continue to require funding for new services or changes to existing agreements. The significant backlog of applications has increased the frustration level of health authorities. All the existing contracts (except one for thoracic surgeons that was negotiated during the period of this review) have expired. Consequently, APP is currently advancing payments, based on historical levels, to health authorities under the assumption that their physician contracts will be renewed.

The agreements between the BCMA and MSC contain compensation ranges for different groups of physicians, as well as transition provisions related to placement of physicians on the new negotiated compensation ranges. However, until all eligible physicians are identified and their payment levels are known, it is not possible to accurately predict the total costs needed and place physicians' compensation in the range accordingly. The ministry has therefore initiated a two-staged transition provisions' implementation process.

The first stage requires placement of all contract and salaried physicians at the minimum level of the new compensation ranges using the transitional provisions of the newly negotiated agreements. The second stage allows the health authorities to adjust the placement of physicians within the ranges after considering a set of factors set out in the agreements. This latter stage, we believe, may be difficult to implement. We noted that a recently signed contract with thoracic surgeons has compensation levels well beyond the maximum level set for the range. This exception may affect the enforceability and credibility of the agreements. There may be good reasons for the decision on the thoracic contract, but it gives the impression that the negotiated range is only a guide, rather than an expectation, for compensation levels.

We believe that this perception can be minimized with a transparent and open application negotiation and approval process. Such a process requires detailed policies and guidelines covering evaluation criteria, documentation of decisions, dispute resolution, and evaluation of expired contracts to assess renewal options. These would not only provide assurance about the integrity of the approval process, they would also enhance staff's ability to provide a fair and equitable assessment of applications and enable the formal appeal of rejected proposals. Previous reviews of APP have indicated that all of these elements are generally lacking.

Recommendation

We recommend the ministry establish clear policies and guidelines for the contract application approval process and clear criteria for the evaluation of new or expired contracts.

Contract terms and conditions between APP contracts are inconsistent and unclear

Contract terms and conditions under APP have always been complex because each type of service requires unique definitions. As a result, contracts have historically tended not to be "standard," instead varying in content and payment mechanisms. This has produced a mosaic of contract arrangements, complicated the establishment of consistent contract terms and conditions, and contributed to difficulties in contract tracking and monitoring. Previous studies have identified a number of specific concerns generated by the inconsistencies between agreements:

- variations in non-compliance, accountabilities, use of surplus funds (funding in excess of contract needs) and billing practices;
- variations in service deliverables and reporting requirements;
- inconsistencies between physician contracts and related APP funding agreements with the health authorities;
- an outdated contract template; and
- lack of standard contract provisions.

The latest round of negotiations resulted in the 2001 Working Agreement and other subsidiary agreements being signed between the government, BCMA and MSC. The subsidiary agreements covered not only compensation ranges for physicians, but also

How APP Negotiates Compensation Levels for Doctors

Negotiations between government and doctors on compensation levels can be challenging and complex. The following fictional account explores some of the typical issues experienced by the Alternative Payment Program in establishing a contract for specialist services.

British Columbia has been fortunate to have three top cardiac surgeons located in Vancouver. Recently, one of the surgeons left to take a higher paying position in the United States of America. As a result, the surgeons were short handed and unable to manage all of the cases, causing cancellation of surgeries and increasing already long wait lists. Only high priority cases were receiving necessary care.

The remaining surgeons requested compensation equal to that obtained by their departing colleague. As well, they thought an increase was necessary to recruit an additional surgeon. A direct comparison of compensation was difficult due to differences in cost of living between the US and Canada and different responsibilities in each position.

The health authority believed that the loss of a cardiac surgeon posed a serious risk to the health of the population. In order to attract an additional surgeon, an increase in the compensation level was considered necessary. The Vice-President of Medicine of the local health authority contacted the Ministry of Health Services to determine if the Alternative Payments Program could be used to secure a higher level of compensation for a new surgeon, as well as the two existing surgeons to ensure parity. Negotiations on the alternative arrangements proved difficult as the amount being requested was much higher than other previous compensation arrangements.

All parties indicated a readiness to negotiate an appropriate level of compensation, but the negotiations eventually became deadlocked. Each party became more frustrated by what each perceived as a lack of movement in trying to reach a settlement. Each was faced with difficult issues in this situation. For example, in order to stay within their budget, the ministry and health authority believed that providing these surgeons with increased funding meant that services elsewhere would need to be reduced. However, the surgeons would like to see their services valued and equitably compensated.

The resulting relationships between the ministry, health authority and the surgeons was severely strained creating an environment of mistrust. It took a prolonged period of time before an APP arrangement could be implemented, leaving the public at further risk during the course of negotiations.

Understandably, there are competing interests between the government and doctors in trying to reach a mutually satisfactory compensation agreement. We have recommended establishing clear policies and guidelines around this negotiations process so that it is as transparent and fair as possible. The underlying tensions brought about by competing interests need to be dealt with in an open manner so that everyone understands each others position better. We believe this will greatly enhance the ability to come to a mutually acceptable negotiated agreement on compensation levels for doctors.

the general terms and conditions, some reporting requirements and services/deliverables, payment terms, and mixed payment conditions for each of type of service arrangement. However, as these agreements are only between the government, BCMA and MSC, agreements still have to be developed between the ministry and health authorities. We believe that the ministry should use these most recent agreements as the building blocks for developing separate APP agreements with each health authority.

Recommendation

We recommend the ministry develop a process to ensure terms and conditions of the contracts with health authorities are consistent with the provincial Working Agreement and subsidiary agreements.

Certain key terms and conditions in the prescribed contract templates with physicians require detailed policies and guidelines

The newly negotiated provincial agreements require all physicians to have contracts (or employment agreements) with their health authorities and to provide base levels of patient information reporting. Included in the agreements are physician contract templates for the health authorities to use. The templates contain mandatory contract provisions, including the allowance for termination if a physician breaches a fundamental requirement or term, and referral of disputes to mediation or an arbitrator. There is also a requirement for physicians to outline services that will be billed under fee-for-service or third parties when those services are delivered outside an APP contract. We believe the templates will provide some assurance that the terms and conditions consistently cascade down from the subsidiary agreements to individual physician contracts.

These are all positive steps towards reducing the risk of terms and conditions being misaligned with the funding and program objectives, and minimizing loss due to billing improprieties and non-compliance. However, we still feel these templates leave a few areas that require further development of policies and guidelines by APP. Those areas include: definition of services/deliverables, reporting requirements, use of surplus funds, consequences for non-compliance, and inspection of records. We also believe APP must provide guidance to the health authorities to ensure the contract templates in the agreements are adopted with minimal modification and are consistent with the agreements with each health authority.

Recommendation

We recommend the ministry develop clear policies, guidelines and definitions for contract terms and conditions on services/deliverables, reporting requirements, use of surplus funds, consequences for non-compliance, and inspection of records.

The tracking and payment process does not ensure payments are made only for services rendered or for valid contracts

We reported earlier that APP's roles and responsibilities may change (with the program's mandate under review) from the micro-management of contracts and payments to high-level policy development and monitoring—that is, focusing on program oversight rather than program management. The decision to make this change has yet to be made by senior management of the ministry. Whatever role APP plays in tracking and payment processing, it is important that expenditures be made only to those who have delivered the services contracted for. Clear policies and procedures must therefore be in place to ensure tracking and payment controls are effective and efficient.

Several weaknesses with payment processing concern us. First, APP prepays health authorities for physician services to be provided under service contracts. However, there is no process in place to ensure that when a health authority pays a physician less than the APP-contracted amounts, program staff are informed for billing adjustment purposes. Program staff are informed only about hours recorded that exceed contract terms and not about hours that are less than contract terms. Second, forms from health authorities are not always signed by designated signing authorities. These weaknesses reflect a lack of clear standards for reporting.

We also noted that some program staff are using spreadsheets on stand-alone computers for tracking contracts. These computers are not linked to each other or to a central computer. This is a concern because, in such an environment, errors can easily be made and can be difficult to trace and update.

Sound and efficient program operations: the program is undermined by weak management systems

Overall, APP's lack of formal policies and procedures for tracking and payment processing raises the risk that errors will remain undetected. Such errors might be billing and payment inconsistencies, payment for non-contracted services, payment for non-compliance, and funding of agencies in excess of their agreements.

Recommendation

We recommend the ministry establish formal policies and procedures to ensure services are rendered in accordance with the agreements and all payments have proper approval and are only made for services received.

Monitoring and compliance activities are almost non-existent

Contract monitoring and compliance have rarely been performed under APP. The ministry's Core Review document points out that these accountability mechanisms have been employed by APP only "where resources permitted." Thus, because of resource constraints, APP program staff have generally spent little time on monitoring. Unclear terms and conditions on reporting requirements and the consequences on non-compliance have also contributed to the lack of monitoring and compliance activities.

Past studies and our own interviews have identified several key accountability concerns, such as:

- funded organizations' non-compliance with service level requirements;
- inadequate and improper maintenance of time and other records;
- unauthorized reallocation of funding and surpluses; and
- contracting for service levels in excess of projected requirements.

Without adequate monitoring and compliance policies and procedures, and without appropriate data collection and analysis tools, there is a risk of financial loss through over compensation or conducting unnecessary investigations. We think that the ministry's plan of integrating sessional APP payments with the fee-for-service system could partially mitigate the risk. We also believe that, in keeping with what health authorities indicated to us, they should be responsible (or at a minimum, be jointly responsible with the ministry) for monitoring physician contracted services.

Sound and efficient program operations: the program is undermined by weak management systems

As it relates to compliance, the audit function is an effective tool in preventative and detective control. Within APP, however, we found such a function to be virtually non-existent. Program staff reported they do not have or employ formal polices and procedures to routinely examine funding recipient records. The Billing and Integrity section of the ministry is primarily responsible for audits of the fee-for-service system. Although it supports investigative work for APP, that effort is more ad hoc in nature and only performed in those rare circumstances where irregularities are identified. In our view, the ministry should consider establishing an audit function separately or jointly with the Billing and Integrity audit section of the ministry.

Recommendation

We recommend the ministry establish clear criteria for monitoring and compliance activities and clear policies and guidelines for managing non-compliance.

Information Technology

The information system is dated and unable to support APP needs

Information technology (IT) requirements for APP have always taken a back seat to those for larger programs such as MSP. The state of APP's information systems is a result of the general lack of IT direction in the program, and a reflection of the environment of significant change and uncertainty. To date there has been no clear IT strategic plan for APP.

Past studies and our review have found that:

- the APP Claims System for sessional agreements has not been updated and is not user-friendly;
- computer applications are not current;
- sources of necessary data are fragmented; and
- reports are unreliable.

Our review also found that APP staff are unable to access adequate and appropriate IT resources and support, and instead turn to manual, paper-based tracking, monitoring and payment processing of claims. As well, there is no online, automated, integrated tracking payment systems for contract administration.

The current APP systems are not linked to central government accounting systems, nor do they have the full ability and capacity to collect and warehouse information such as patient encounter data. Aside from the management and operational problems, the unreliability of information has reduced the ability of program staff to make meaningful projections and develop well-informed plans.

We have learned that an information technology business analyst (0.25 full-time-equivalent) has recently been assigned to APP to explore opportunities of how technology can improve the tracking/monitoring and payment process. As well, the ministry is considering different options in developing a system that will improve access and would include consistent reporting requirements.

Whether the IT systems upgrade or maintenance activities are carried out in-house or by external parties, it is time for the ministry to prepare an IT strategic plan, define the information requirements for decision-making needs of the program, identify unreliable systems, and create an information environment that is integrated with other programs. Strong executive support will be required to ensure the program is supported by an adequate information system. Left unchecked, these issues will only intensify as contracting for services continues to grow.

Recommendation

We recommend the ministry establish an IT strategic plan aligned with APP objectives and identify and analyze alternative technology opportunities against operational requirements.

Results-focused program performance: the program is unable to demonstrate what it has achieved

Performance Measurement and Reporting

Measuring and reporting on performance is the fourth element in the public sector performance management framework, after establishing clear objectives, effective strategies and aligned management systems. It is a critical step in ensuring that a program is accountable and being managed well.

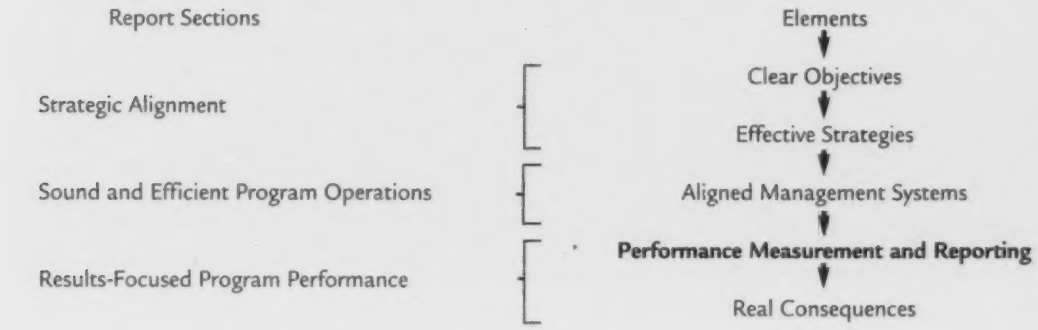
APP is unable to measure its results to demonstrate that it has been effective

We found that the ministry does not have a very good understanding of what APP has accomplished. No formal performance measures have been developed to provide an indication of program results.

We reviewed a variety of internal documents, including APP budget/expenditure figures and statistics, and a draft document prepared for the ministry's Core Review in 2001/02. The program statistics and financial data we found provide useful, but very basic program information (e.g. dollars expended/committed, number and size of contracts, and service types funded). The internal Core Review document proposed the following performance indicators, although these are not currently used by the ministry:

- increase in physicians receiving all or part of their income through APP
- increase in applications to APP

Performance Management Framework (see Exhibit 4, page 15)



- number of new contracts in rural communities
- number of new sessional agreements approved
- stabilization of services by example e.g. cancer treatment
- dollars expended to support Clinical Academic Service Contracts

These measures are focused on inputs or outputs. Inputs are the resources dedicated or used by the program (e.g. dollars expended). Outputs are the direct products or activities of the program (e.g. number of new contracts approved). However, even if these indicators were adopted by APP, this approach lacks an important dimension of program performance—measuring its intended results. Intended results are the desired outcomes associated with meeting the goals and objectives for the program.

We believe APP should be focusing its efforts on outcomes because these types of measures provide an indication of the program's effectiveness. Exhibit 9 compares output and outcome measures and illustrates why the latter are useful.

Currently, the ministry does not include APP performance information in its service plan or annual service plan report. Consequently, there is no linkage between what APP does and how it contributes to the ministry's goals or objectives.

Exhibit 9

A comparison of the output measure and the outcome measure

Output	Outcome
Efficiency, Productivity Products, Services	Effectiveness Results, Impacts
e.g. Treated patients	e.g. Discharged patients capable of living independently
This measure:· ▪ Tells how many people went through the program. ▪ Doesn't show the effect the program had on the people it treated.	This measure:· ▪ Indicates the change in people's lives after completing the program. ▪ Shows whether or not the program achieved its objective of independent living for patients.

Source: Adapted from *Performance Measurement in the B.C. Public Service*, Learning Services, Public Service Employee Relations Commission and Treasury Board Staff, 2003.

Results-focused program performance: the program is unable to demonstrate what it has achieved

Both the ministry and health authorities told us they want to move towards using outcome measures. According to the ministry, however, it is a long way from being able to determine what would constitute appropriate outcome measures because of the complexities of the services provided and the need to develop program objectives first. This point is discussed further in our next finding.

The development of outcomes-based performance measures will not be easy. It will require a major cultural shift in accountability practices for physician compensation. The traditional fee-for-service system emphasizes an activity-based orientation. Modern day accountability refocuses efforts towards results, which in this case directly refers to health outcomes. A test of accountability for this program resides in how it can demonstrate that it contributes to improving a patient's health, as opposed to providing the number of procedures performed for that patient.

Recommendation

We recommend the ministry develop performance measures that focus APP towards results and ensure these measures contribute to those adopted for the ministry overall.

APP has not developed performance measures and believes it needs to develop program objectives first

Developing performance measures for APP is a low priority for the ministry. It says it first needs to set out clear objectives for the program. While this is a reasonable assumption on one level, we believe development of performance measures should be part of the same process used to develop program objectives. Ideally, the ministry should begin a business planning approach that brings together these two important elements.

We recognize the development of performance measures for APP is complicated because there is no consensus on what are the right measures for the program. Some guidance on this issue is contained in our May 2003 report, *A Review of Performance Agreements Between the Ministry and Health Authorities*. The report outlines the following approach to obtain a balanced set of measures and this, we think, could be used for APP.

Results-focused program performance: the program is unable to demonstrate what it has achieved

"Developing a useful set of performance measures for health care requires a systematic approach that includes:

1. selecting a guiding set of principles for reporting;
2. creating a framework of types of measures;
3. applying sound methods to choose measures within the selected frameworks; and
4. using logic models to identify and select measures of outcomes."

The report further recommends using the eight guiding principles established by the Steering Committee on Reporting Principles and Assurance to guide the performance measure selection process (see Exhibit 10). This steering committee was established in 2002 by the Select Standing Committee on Public Accounts and is staffed jointly by our office and government.

Once the principles have been agreed upon, a conceptual framework of measures is needed. The framework recommended by the above report could be used or adapted to fit APP. It includes the following types of measures:

- service levels and access
- service quality and appropriateness/client outcomes
- client satisfaction
- financial results
- efficiency/productivity
- sustainability/capacity

Exhibit 10

Eight guiding principles for selecting performance measures in the public sector

- Explain the public purpose served.
- Link goals and results.
- Focus on the few, critical aspects of performance.
- Relate results to risk and capacity.
- Link resources, strategies and results.
- Provide comparative information.
- Present credible information, fairly interpreted.
- Disclose the basis for key reporting judgements.

Source: Office of the Auditor General *A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities*, May 2003

Results-focused program performance: the program is unable to demonstrate what it has achieved

Many interviewees said program measures are often too focused on the financial dimension without adequate consideration of service delivery and internal management. We think this framework addresses this concern.

There also needs to be a well-planned process that brings the relevant participants to the table so that ownership and commitment towards meeting the measures is present. This process should, at a minimum, involve both the ministry and health authorities. If external stakeholders can also be included in the selection process, such as representatives of the BCMA or service providers, an even greater commitment to meeting the measures will be garnered.

One tool that could be helpful to the ministry in developing outcome-related performance measures is the logic model. Such a model was used to develop the ministry's latest service plan. Exhibit 11 provides two program examples that demonstrate the continuum which is the basis of a logic model.

Exhibit 11

Excerpt from the Office of the Auditor General's *Quick Reference Guide to Performance Measures*, November 2001

PROGRAM	Driver Licensing Program	Silviculture Program
Inputs	Budget $ FTEs	Budget $ FTEs
Activities	Reviewing applications Activities Issuing	Site preparation Planting/tending of seedlings
Outputs	Applicants tested Licenses issues	Trees planted Hectares of site prepared
Immediate Outcomes	Only qualified drives are on the road New drivers have appropriate skills	Resource base is sustained or increased
Immediate Outcomes	Fewer, and less severe accidents	Forest industry is profitable
Ultimate Outcomes	Savings in health care and insurance costs	The provincial economy is healthy

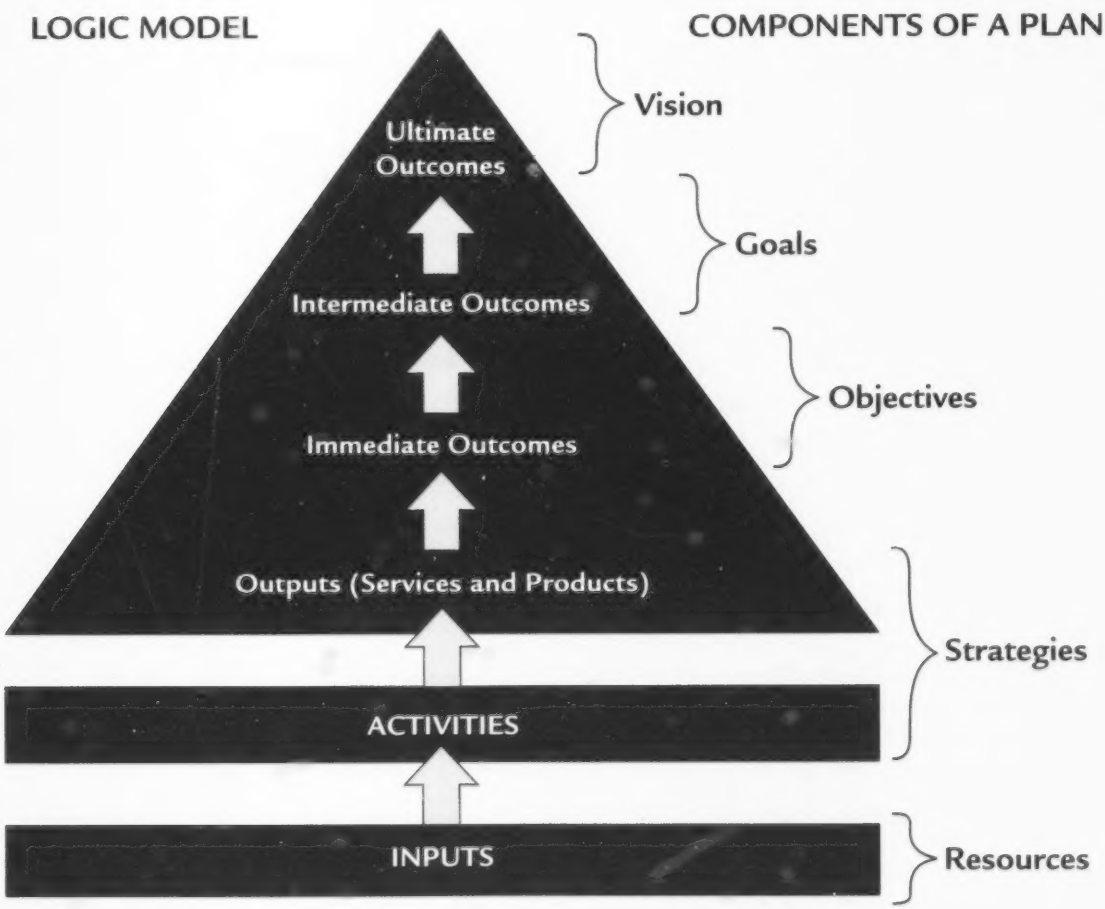
Source: Adapted from draft *Guidelines for Performance Measurement in British Columbia Government*. Treasury Board Staff, Ministry of Finance and Corporate Relations, November 1986

Results-focused program performance: the program is unable to demonstrate what it has achieved

Exhibit 12 illustrates how the development of performance measures along a continuum fits with the business planning approach we are recommending.

Exhibit 12

Logic model as a foundation for planning



Source: *Performance Measurement in the B.C. Public Service*, Learning Services, Public Service Employee Relations Commission and Treasury Board Staff, 2003.

Results-focused program performance: the program is unable to demonstrate what it has achieved

In developing its own set of performance measures, we think that the ministry and health authorities should look to various examples in the health care field. Ontario's APP, for example, established a joint committee that included representatives from the provincial ministry as well as service providers. This joint committee established an accountability framework for the program that included three main elements: domains, deliverables and measures. The domains are a high level description of a specific subject/knowledge area:

- clinical services;
- medical education;
- research and scholarly activity; and
- non-clinical and/or administrative medical service delivery.

Deliverables flow from each of these domains. Examples include maintaining or improving the quality of care, maintaining or improving accessibility to clinical services, evidence of quality in teaching, delivery of scholarly activity, and the promotion of physician participation in health system functions. Measures were then developed for each deliverable and include indicators such as research productivity, waiting times, unplanned readmissions to hospital, and changes in same-day surgery rates.

Other examples to consider include the Canadian Council on Health Services Accreditation (CCHSA) performance indicator list and the Canadian Institute for Health Information's (CIHI) list of health indicators. CCHSA is the major national accrediting body for health organizations in Canada. Service providers funded by APP may already be part of the CCHSA accreditation process. CIHI is a federal/provincial organization working to improve the health of Canadians and the health care system by providing quality, reliable and timely health information.

Recommendation

We recommend the ministry establish APP performance measures along a continuum (including patient health outcomes), using a process that is linked directly to the development of program objectives.

APP has not defined targets to indicate whether the program has been successful

Specific expectations have not been set out for what APP is to achieve. Consequently, it is not possible to determine if the program has been successful or needs to adjust course. As is the case with establishing performance measures, setting targets is not a high priority for the ministry.

Typically, a program sets targets based on its performance measures. Our office's report on performance agreements again provides some useful guidance in this area. It says that targets should be:

- clear and measurable;
- based on sound benchmark or comparator data;
- striving for continuous improvement; and
- tied to incentives and consequences.

Many other information sources provide useful insight into how appropriate targets can be set. Ontario's APP describes three levels of quality that it uses to set targets:

- internationally or nationally recognized expectations or target levels of performance;
- provincial expectation/targets; and
- local targets.

Specific examples of Ontario's APP targets are available through the South-eastern Ontario Academic Medical Organization, which includes the three principal teaching hospitals and the Clinical Teachers' Association of Queen's University.

Another resource available to APP is Treasury Board Staff's *Guidelines for Service Plans 2003/04*. It provides target-setting criteria at the ministry level, but they are also relevant for the program. According to the guidelines:

"Targets express pre-set quantifiable performance levels to be attained at a future date. They help the reader to assess whether the level of achievement is satisfactory. Targets should be reasonably challenging and should not be set just to the minimum level of performance. Ministries should set targets (or expected results) for each of the performance measures in the service plan."

Results-focused program performance: the program is unable to demonstrate what it has achieved

Performance targets should take into account the following factors:

- Past output/outcome levels (baseline) or their trend over the years (trend line) provide a starting point for setting future targets and helps the public assess the success of the ministry in attaining new targets or improving trends.
- Targets and their base values are logically sound, and they measure reliably what they are intended to assess.
- Lag time before the outcomes are expected to occur or become measurable."

The development of well-defined targets is expected to take time to implement, and the cultural shift and complexities involved in increasing accountability cannot be underestimated.

Recommendation

As part of the process of developing performance measures, the ministry should also establish targets which identify clear expectations of what is to be achieved by the program.

Monitoring of APP is limited so the program is not being held accountable

Typically, public sector programs are held accountable to the public in two main ways: through the Legislature and through regular internal review of program results by management. We found that, aside from providing basic financial information, APP has had difficulty fulfilling either of these obligations.

For the public, the key performance accountability documents of a ministry are its service plans and annual service plan reports. These documents are tabled in the Legislature by the Minister of Health Services and describe respectively, what the ministry expects to accomplish and what it has actually accomplished. APP has minimal input into either of these ministry documents and has not been directly referred to in them—only general references are made to the provision of physician services.

Results-focused program performance: the program is unable to demonstrate what it has achieved

On financial matters, APP budget and expenditures are incorporated into the $2.5 billion figure for MSP shown in the Estimates. There is a small reference to this fact in the vote description for MSP. If asked, the minister is prepared to respond to questions that arise on APP during the legislative debates on the ministry's budget. Internal background material is prepared for this purpose, but is not meant for public readership.

Within the ministry, there is no regular monitoring of APP performance, although program management issues are discussed fairly frequently—because of the crisis management nature of this program. Issues of the day such as threatened work stoppages by physicians are brought forward on a priority basis and through bi-weekly updates between the assistant deputy minister and deputy minister. Financial reports are routinely received and reviewed by the program area, but are not discussed on a regular basis with senior management.

According to the ministry, because APP represents only 2 to 3% of its $10.2 billion budget, it is too small to identify separately to the Legislature. While these numbers are accurate, we wish to point out that APP still spends more than 10 of the 20 ministries in British Columbia. It is not a small program. We therefore believe that reporting on APP on an aggregated basis through MSP is *not* very informative to the public. Additional information should be provided through the ministry service plan and annual service plan report to appropriately account for both the performance and dollars being spent on this program.

In addition, we believe the limited attention given to APP internally compounds the strategic and operational problems already highlighted in this report. There needs to be greater monitoring at senior levels to ensure the program is well run.

Recommendation

We recommend the ministry provide greater detail in its service plan and annual service plan report to identify the program and how it contributes to the overall direction of the health system and conduct regular performance and expenditure monitoring at the senior management level.

Program-level reporting requirements are not linked to program results and are controversial to implement

The program collects extensive patient information under its current contractual reporting requirements. However, these requirements were not developed with objectives-based program results in mind, nor is the information collected used for decision-making purposes.

For APP service contracts, we found that approximately 70% of the information collected is submitted manually (e.g. handwritten on forms) and then filed by the program area. The information is too cumbersome to be collated or entered electronically into a database for analysis or use in decision-making. Another 15% is captured electronically through the fee-for-service system and the remaining 15% of the information goes uncollected. No patient data is collected for sessional or salaried doctors.

However, most of the data collected is not used and the quality of the information collected is questionable. According to the ministry, the handwritten information received is often illegible. Other interviewees also told us that because physicians know the information is not used for billing or decision-making purposes, there is not likely to be much effort into ensuring the information's accuracy.

Questions were also raised about the administrative workload required, the relevance and usefulness of the information collected and the philosophical link to the fee-for-service system. On the latter point, for example, physicians likely enrol in an alternative payment arrangement because of the perceived weaknesses of the fee-for-service approach. Thus, to them, APP's adopting the same reporting requirement would seem counterintuitive.

The lack of appropriate reporting standards for APP has been a long standing issue in the administration of the program. Previous reviews (including our office's 1994/95 MSP audit, the 1999 Funded Agencies Review and the 2002 consultant's report) have all commented on it.

The ministry has also long understood that the matter is a contentious one. That is why it took steps to specifically include the fee-for-service reporting requirement within the last set of negotiations related to the Subsidiary Agreements (these agreements are described earlier in this report).

This new requirement includes what is necessary for MSP billing purposes, a per-transaction accounting of the services provided to patients. This system is quite detailed and involves many different codes—even for one type of transaction. For example, physical examinations has 10 fee codes.

The ministry indicated it wanted this reporting provision because it is trying to build a comprehensive provincial database of patient information, rather than using it as a means to measure APP performance. This rationale is not well known by many of the people involved in the program.

In our view, there is little benefit to the program having this detailed information, if it cannot be used to demonstrate program outcomes or make administrative decisions such as funding allocations. The information needs to be used and needs to make a difference, otherwise—why collect it?

We believe the reporting requirements for APP need to be carefully re-considered. In particular, the ministry should ask itself whether it really intends to use the information it will gather from the new reporting requirements to assess APP results. If the information is being used to populate the provincial patient information database, then the ministry should acknowledge this and not assume that it is a stand-in for program performance reporting. Whatever the ministry decides should be clearly communicated to health authorities and external stakeholders.

Results-focused program performance: the program is unable to demonstrate what it has achieved

In choosing appropriate program reporting requirements, the ministry could consider the following questions to guide its decision:

Content:	What information is relevant to assessing program performance and what links to performance measures and targets are needed?
Frequency:	How often will the information be used for decision-making or collated for program performance reporting?
Timing:	When is the information reasonably available?
Medium:	What is the most efficient method to collect the information?
Data source:	Where can the information be obtained?
Costs:	Do the benefits outweigh the costs of the reporting requirements?
Data quality:	What process is in place to ensure the information received is accurate?

Information systems will need to be developed to support the reporting requirements of the program. These systems should tie into the broader IT strategic plan recommended earlier in this report.

In developing program level reporting requirements for APP, we reiterate the need for the ministry to pursue a collaborative process with the health authorities and other stakeholders including representation from the physician group.

Recommendation

We recommend the ministry develop program-level reporting requirements and information systems based on the decision making needs, including those focused on outcomes that are expected to be achieved.

Results-focused program performance: the program is unable to demonstrate what it has achieved

There has not been an evaluation of the difference APP makes in the health system

The reviews over the last 10 years have focused on internal program management activities. None have been an in-depth assessment of whether the program is effective or how it can be improved to better meet its public policy aims.

We believe a fundamental evaluation of the program should be done. The ministry needs to reassess what makes APP a valuable part of the health care system, and why. It also needs to take a deeper look at the pragmatic (objectives-based) and economic (cost-effectiveness) aspects of the program before significantly restructuring or growing the program.

A full program evaluation can be very costly and time intensive, but a number of studies are available that would give the ministry a starting point. The CIHI report, *The Status of Alternative Payment Programs for Physicians in Canada, 1999/2000* provides a comparison of the various alternative payment programs in a range of jurisdictions. Several academic studies evaluating the alternative payments approach have also been undertaken in recent years. The ministry should tap into these existing resources to initiate the process of evaluating its own program.

It is important that the results of such an evaluation feed into the ministry's development of an APP business plan—in particular, its vision, goals and objectives. Otherwise, the ministry could be setting out on yet another change initiative without clearly understanding what works and what does not with this program.

Recommendation

We recommend the ministry put in place ongoing program evaluation that demonstrates how APP adds value to the provincial health care system.

Real Consequences

As the fifth element in the performance management framework, real consequences relate to how program decisions are made and whether program adjustments are identified and acted upon.

Consequences for APP lead to an overall lack of both program accountability and administrative effectiveness

- Lack of strategic alignment

The program does not have clear objectives to be able to assess whether it is strategically aligned with broader government and ministry direction. As a result, the program is pulled in the direction of the current crisis with no business plan or policies/procedures in place to resist this type of ad hoc behaviour. As already detailed in this report, APP suffers from several well-recognized deficiencies, yet despite intentions to the contrary, no significant adjustments have been made to the program.

- Lack of sound and efficient program operations

Decisions made on budgeting, human resources, contract management and information technology are not based on a thorough analysis of the impacts to the program. For example, budget decisions are based primarily on the previous year's funding levels without reviewing whether specific services are still appropriate to fund. The impact of how these decisions affect program results are not assessed.

- Lack of results-focused program performance

APP has had no performance measures or targets to indicate program achievements over the last 35 years. Reporting requirements are not based on program outcomes or decision-making needs, and there has been very little monitoring and reporting of program results either to the public or internally. In addition, the APP is unable to demonstrate its value to the health care system, aside from being a different payment mechanism for physicians than the fee-for-service system.

Results-focused program performance: the program is unable to demonstrate what it has achieved

The ultimate consequence is that APP cannot demonstrate accountability for results and is severely hampered by a lack of administrative effectiveness. We recommend a number of basic program management processes and tools to improve the program. These processes and tools flow from the performance management framework we have used to assess the program.

We recognize that establishing greater accountability and improving program effectiveness is complicated by the extensive services APP covers and by the external factors that influence how the program is managed. To mitigate these factors, the program needs to stop being reactive and crisis driven. The ministry, together with the health authorities and key stakeholders need to turn the program around and proactively set the stage to make it effective and credible.

Recommendation

We recommend the ministry use the performance management framework that was jointly developed by the Deputy Ministers' Council and our Office to guide efforts in improving the accountability and management effectiveness of APP.

Response from the Ministry of Health Services

Response from the Ministry of Health Services

General Comments

The Ministry of Health Services (MoHS) is committed to strengthening accountability throughout the public health system and ensuring full public confidence in how the system is governed and managed. There has been considerable progress toward the implementation of clear accountability mechanisms, transparency, and rigor in the Ministries' relationships with the health sector in this province over the last two years.

This review of the Alternate Payments Branch by the Office of the Auditor General was requested by the Deputy Minister of Health Planning and Health Services. The challenges facing this important physician compensation program both internal, and particularly external, are numerous and, as the Auditor General has articulated, they are longstanding. However, as the Ministry moves forward with a clear vision of a high quality, sustainable health care system, the alignment of key components of the health sector, including physician compensation, with the goals and vision of government is of fundamental importance.

As the Auditor General has pointed out, physician compensation accounts for a large proportion of both the Ministry's budget and that of the whole government. The great majority of these funds flow through the Medical Services Commission as Fee for Service compensation. The APP has played a minor but important role by providing an alternative model of compensation for physicians working in unique areas or providing a more holistic set of services to specific patient groups. FFS medicine as the predominant model for physician compensation in Canada and BC has not historically been associated with effective mechanisms for accountability since its inception in the early days of Medicare.

In this province and indeed across the country, FFS is strongly associated by our physicians with professional autonomy and independence. This need for independence and autonomy is part of the cultural context in which the APP program is endeavouring to establish clear accountability mechanisms. This tradition arises out of both the concept that broad flexibility at the level of the individual physician is necessary in order to achieve best outcomes for patients and a broadly held generic distrust by physicians of administrative structures, guidelines and policies which is well described in the medical literature. This creates an environment in which there is significant resistance to the establishment of mechanisms for accountability and firm policy constructs. Although the Ministry acknowledges and agrees with the OAG in calling for such changes, we

feel there is insufficient acknowledgement in the report of the difficulty in moving forward this agenda and the significance of the very difficult dynamics of the environment in which this program is operating.

The Ministries are in strong agreement with the OAG that a first and critical step towards success in this area requires stability in leadership, clear program objectives, performance measures, and policies along with appropriate staff resources and business systems. In addition, as mentioned above, the program is attempting to align the funding flowing through this program with overall government objectives and priorities, something which is also not necessarily consistent with the operating paradigm of physician/health sector relationships. This work has already begun and will be accelerated based on the recommendations in this review. Secondly, much work over the past year has been done with the Health Authorities to assure that their financial and physician human resource policies and procedures allow them to adequately account for both the funding allocated to and services delivered by the physicians funded through APP contracts. However, they too face significant resistance to the implementation of such accountability mechanisms. The resistance of many physicians in the province to the signing of contracts for on-call payments (total program allocation $125 million/year) is a good example of this.

It is clear that the context in which this program operates will require significantly more than the tightening of program management, program controls and policies to meet the challenges facing it. This relatively small program (in the broader context of physician compensation) has functioned in an environment of volatility, and frequently rapidly escalating pressures brought through threats of lapses in patient services, often in critical areas of care. Furthermore, the complexity and diversity of funding sources for physician compensation and the manner in which these dollars are currently attached to the physician rather than to patient need or government's identified priorities, present significant challenges to change the focus from established practice to patient centered access to medical services.

The Health Authorities, who operate at the interface of the physician/patient interaction, frequently and understandably turn to the Ministry and this program in times of crisis, looking for solutions to crises of care which are not necessarily amenable to existing or well thought out program guidelines or in some cases negotiated rates of pay. These crises are often played out in the media, at all levels of government, and in an

environment in which the public become unclear that we are able to protect their interests.

Slowly the Ministry is changing this dynamic—through many of the mechanisms suggested by the Auditor General. Key steps were taken by MoHS in the last round of negotiations to begin to put a contractual framework around APP. However, the problems and the demand for solutions far outstrip resources available for this program. Furthermore, the unpredictability of the mechanisms and timeframe in which pressure is brought to bear is growing. As an example, following the signing of the BCMA/MOHS agreement in November 2002, the Ministry staff put in many hours working with the appropriate stakeholders on the development of a framework for emergency physicians contracts, based on negotiated rates of pay and the currently available workload data. There continues to be a misunderstanding and a lack of acceptance among many physicians that they are indeed constrained by the negotiated agreements and broader policy frameworks. Indeed, in spite of the existence of the negotiated contract, due to the unique status of physicians as independent entrepreneurs, there is no legal obligation on the part of individual physicians to adhere to its provisions. These misunderstandings have absorbed hundreds of hours of senior ministry staff time and been associated with both threatened and actual job action at many emergency departments since the signing of the contract last November 2002. Although this process is now beginning to come to a constructive resolution between many of the emergency room sites, the health authorities and the Ministry; the process has taken significant time and resources at the Deputy Minister, senior management and staff level away from developing and improving a management framework for the program. This scenario is repeated again and again in the context of managing new demands for alternative compensation arrangements and is indicative of the complexity and difficulties of the broader systemic culture in which the program operates.

Thus, there is much work to be done to continue to clearly articulate the direction for the program, continually clarify the ground rules, negotiated elements and the policy frameworks supporting the program, and work needs to be continued with the Health Authorities and physicians in the province to ensure that the program retains sufficient flexibility in its design to meet the changing needs of the public and the health system. The strong support of the OAG for clarity in these areas is welcome.

Furthermore, we agree and it is obvious that as the AG has stated, implementing many of the recommendations will require the commitment and explicit leadership of health authorities, physicians and stakeholder representatives, including the BCMA. All these parties are key to shifting the culture and structure of accountability to focus more on patient outcomes and making the changes necessary for effective program management. While some of the recommendations in the report will be challenging to implement within the current context, they will be a valuable reference point as the work progresses.

This review gives the ministry, and the dedicated APP staff, the opportunity to move forward and it will be used to work constructively with all the stakeholders to ensure our priorities, accountability mechanisms, and the principles by which they are developed, are clear, transparent and effective.

The Ministry has commenced action on many of the recommendations in this report. In particular, it has already acted to co-locate the various physician alternate compensation programs under a single Physician Compensation branch with in the Ministry. Fee for service will be also managed from this branch in the coming fiscal year. As a result, the new branch will be responsible for all physician compensation programs. With the presentation of this report, the Ministry will now undertake the required action to strategically align the program, ensuring its sound and efficient management, with a results oriented focus. While it will clearly take the better part of the next eighteen months to fully implement the recommendations set out by the OAG, the Ministry intends to take significant steps in this direction over the balance of this fiscal year.

A. Strategic alignment: APP lacks clear objectives and effective strategies to ensure alignment with ministry direction.

1. Develop clear and achievable program objectives for APP that align with the ministry's and government's overall direction.

The ministry agrees program objectives must align with the overall direction of government and need to be defined clearly and understood by all the stakeholders. Even though the workload of implementing the last negotiated BCMA/Government Agreements has been significant, the Physician Compensation branch has commenced developing an operational plan for the program

area that establishes clear program objectives aligned with the government's direction, goals and strategies as per the 2003/04–2005/06 Service Plan for the MOHS. *This will be subsequently updated annually as part of the Service Plan development and Divisional Accountability Plans.*

2. Conduct a business planning process in order to establish a well defined approach for managing APP.

   The ministry is incrementally using business-planning processes in its stewardship role and will do so in managing its physician compensation programs, inclusive of APP. The Physician Compensation branch will clearly articulate these processes through its policy and procedures material by fiscal year end.

3. Develop a comprehensive and publicly accessible policy and procedures manual to ensure consistency in program administration.

   The process of revising and developing the policy and procedures manual is underway. The physician compensation branch will make its policies and procedures accessible through the ministry and physician websites by fiscal year end.

4. Establish specific policies and procedures to deal with crises in a consistent manner, as part of a comprehensive policies and procedures manual.

   Through structured discussions at the Ministry Executive, the regular meetings of the Leadership Council (chaired by the Deputy Minister) and the Committee of Vice Presidents responsible for Physician Resources in the Health Authorities (chaired by the ADM Medical and Pharmaceutical Services), the Ministry has established clear mechanisms for regular discussion of emerging issues, pressures, priorities and problems. In consultation with these key partners, the ministry will now move to establish specific policies to deal with crises in a consistent manner.

5. Implement changes linked to broader planning and evaluation processes for APP to reduce the ongoing impact from program instability.

The intent of asking for this review was to identify systemic issues in the management of the program and contextual barriers to moving ahead with needed changes that will contribute to the government's overall agenda of improving the quality of care and outcomes for patients within a sustainable budget. The recommendations identified in this report provide a solid foundation for at least moving on the management agenda and will be acted on in the coming six months. This action will embed the program in the broader planning, management and evaluation processes of MoHS and bring a level of stability to the program on a go forward basis.

6. Improve the coordination and effectiveness of all its individual compensation programs by establishing an overarching physician compensation framework that outlines each program and illustrates program linkages.

As noted the ministry has recognized the lack of integration regarding physician compensation programs and in January 2003 created an organizational structure to realign the majority of physician compensation programs (Rural Subsidiary programs, Rural Specialist Locum Program, Doctor of the Day, Medical On-call/Availability, academic contracts, HealthMatch BC, and APP) under one Executive Director. There is ongoing discussion regarding the parameters of this portfolio with the intent to include fee for service compensation under the newly named Physician Compensation Branch.

B. Sound and efficient program operations: APP is undermined by weak or inadequate management systems.

7. Formalize a budgeting process that addresses the program's strategic goals and the continuing need for existing contracts.

A budget exists for APP but the ability to plan for annual expansion is severely constrained by the very limited control that MoHS exercises over the allocation of physician compensation.

which is largely controlled by existing agreements with the BCMA and their internal processes for allocating budget increases for compensation. This is a key issue for MoHS on a go forward basis.

8. Develop detailed policies and guidelines to govern the calculation of transfers from the Available Amount to APP, to ensure consistency and transparency in decision-making.

As stated in the OAG report, a Transfer Review Committee has been established to approve recommendations for the transfer of funds from the Available Amount (AA) to APP. The committee has established terms of reference and a methodology for transfer. Specific policies and guidelines are being developed to ensure transparency in decision-making.

9. Conduct a thorough business analysis based on the future direction of APP before it decides what is required in terms of a staff complement.

A human resources analysis will be done as part of the change management strategy that will arise from this report.

10. Improve how it communicates with health authorities to ensure both parties understand each other's expectations.

As noted in the report this is a shared accountability for the ministry, health authorities and physicians, requiring improvement by all parties in line with the recommendations of this report. The ministry will take a leadership role in facilitating this process and has already done this through regular meetings of the committees outlined in the response to recommendation 4.

11. Commit to creating greater stability in APP's leadership structure so that consistent, clear direction is provided.

The creation of the portfolio of ADM Medical and Pharmaceutical Services was a clear signal of the commitment of the Ministry to explicit leadership at the executive level for this area. Recruitment leadership at the program level is in process.

12. Establish clear policies and guidelines for the contract application approval process and clear criteria for the evaluation of new or expired contracts.

The ministry agrees with this recommendation as part of the overall policy and procedures development.

13. Develop a process to ensure terms and conditions of the contracts with health authorities are consistent with the provincial Working Agreement and subsidiary agreements.

This recommendation has already been completed with a new contract template, consistent with the negotiated agreements.

14. Develop clear policies, guidelines and definitions for contract terms and conditions on services/deliverables, reporting requirements, use of surplus funds, consequences for non-compliance, and inspection of records.

Subsequent to the negotiation of the 2001 Working Agreement and the Provincial Service, Salary and Sessional Subsidiary Agreements, these elements have been more clearly defined as part of the MoHS/Health Authority contracting process. These definitions and expectations will be included and further expanded on in the development of program policies and procedures.

15. Establish formal policies and procedures to ensure services are rendered in accordance with the agreements and all payments have proper approval and are only made for services received.

The ministry already clearly states the responsibility of the HA's to comply with negotiated parameters. Health Authorities also have access to the Health Employers Association of BC (HEABC), as the negotiating agent for government, to assist them in properly interpreting the agreements.

MoHS will further strengthen its financial payment and audit capabilities over the balance of this fiscal year.

APP will make explicit related policies and procedures part of its manual.

16. Establish clear criteria for monitoring and compliance activities and clear policies and guidelines for managing non-compliance.

As indicated above, the ministry will strengthen its monitoring and compliance criteria as part of its ongoing action plan arising from this report.

17. Establish an IT strategic plan aligned with APP objectives and identify and analyze alternative technology opportunities against operational requirements.

This will be part of the MoHS action plan outlined above.

C. Results-focused program performance: APP is unable to demonstrate what it has achieved.

18. Develop performance measures that focus APP towards results and ensure these measures contribute to those adopted for the ministry overall.

The ministry agrees that health outcome measures are important in evaluating value for money expenditures on physician compensation. However, this will be a longer-term process as the ministry increasingly focuses on health outcome measures as part of its service delivery planning.

19. Establish APP performance measures along a continuum (including patient health outcomes), using a process that is linked directly to the development of program objectives.

20. Establish targets which identify clear expectations of what is to be achieved by the program.

With the establishment and approval of objectives for the Physician Compensation branch, the first step will be to start concretely linking and then evaluating compensation methods for their contribution to ensuring the right services are provided by the right person, at the right time, in support of the ministry's overall goals. As part of its overall change management process the Physician Compensation branch will set clear targets of what it expects to achieve on both a longer term and annual basis.

21. Provide greater detail in its service plan and annual service plan report to identify the program and how it contributes to the overall direction of the health system and conduct regular performance and expenditure monitoring at the senior management level.

    The ministry will ensure there is appropriate detail in both the divisional and ministry service plans outlining the program and its contribution to the overall strategic agenda of the ministry. Routine performance and expenditure monitoring procedures will be clearly set out in its policy and procedures manual.

22. Develop program-level reporting requirements and information systems based on the decision making needs, including those focused on outcomes that are expected to be achieved.

23. Put in place ongoing program evaluation that demonstrates how APP adds value to the provincial health care system.

24. Use the performance management framework that was jointly developed by the Deputy Ministers' Council and our Office to guide efforts in improving the accountability and management effectiveness of APP.

    These will be addressed as part of the change management process for the program over the coming six months.

In closing, the Ministry's response to the report of the OAG will be vigorously pursued over the coming six months and actions implemented by the end of the 2004/2005 fiscal year. The broader contextual challenge of pursuing potential structural and systemic change that ensure the accountability that tax payers dollars are clearly targeted to government priorities, focused on quality patient care and outcomes, remains a critical and ongoing task for government, the ministry, health authorities, the BCMA and physicians, over the coming years.

Appendices

Appendix A: Summary of Recommendations

While our recommendations are addressed to the ministry, we believe implementing many of them will require the effort and commitment of health authorities, physicians and stakeholder representatives, including the BCMA. It is clear that all of these parties will need to take part in both shifting the culture of accountability to focus more on patient health outcomes and making the changes necessary for effective program management. All parties involved have an obligation to ensure the program is properly accountable to British Columbians and transparent in its use of taxpayer dollars to the benefit of patients.

Strategic alignment: the program lacks clear objectives and effective strategies to ensure alignment with ministry direction.

We recommend the ministry:

1. Develop clear and achievable program objectives for APP that align with the ministry's and government's overall direction.
2. Conduct a business planning process in order to establish a well defined approach for managing APP.
3. Develop a comprehensive and publicly accessible policy and procedures manual to ensure consistency in program administration.
4. Establish specific policy and procedures to deal with crises in a consistent manner, as part of a comprehensive policies and procedures manual.
5. Implement changes linked to broader planning and evaluation processes for APP to reduce the ongoing impact from program instability.
6. Improve the coordination and effectiveness of all its individual compensation programs by establishing an overarching physician compensation framework that outlines each program and illustrates program linkages.

Appendix A: Summary of Recommendations

Sound and efficient program operations: the program is undermined by weak management systems.

We recommend the ministry:

7. Formalize a budgeting process that addresses the program's strategic goals and the continuing need for existing contracts.
8. Develop detailed policies and guidelines to govern the calculation of transfers from the Available Amount to APP, to ensure consistency and transparency in decision-making.
9. Conduct a thorough business analysis based on the future direction of APP before it decides what is required in terms of a staff complement.
10. Improve how it communicates with health authorities to ensure both parties understand each other's expectations.
11. Commit to creating greater stability in APP's leadership structure so that consistent, clear direction is provided.
12. Establish clear policies and guidelines for the contract application approval process and clear criteria for the evaluation of new or expired contracts.
13. Develop a process to ensure terms and conditions of the contracts with health authorities are consistent with the provincial Working Agreement and subsidiary agreements.
14. Develop clear policies, guidelines and definitions for contract terms and conditions on services/deliverables, reporting requirements, use of surplus funds, consequences for non-compliance, and inspection of records.
15. Establish formal policies and procedures to ensure services are rendered in accordance with the agreements and all payments have proper approval and are only made for services received.
16. Establish clear criteria for monitoring and compliance activities and clear policies and guidelines for managing non-compliance.
17. Establish an IT strategic plan aligned with APP objectives and identify and analyze alternative technology opportunities against operational requirements.

Results-focused program performance: the program is unable to demonstrate what it has achieved

We recommend the ministry:

18. Develop performance measures that focus APP towards results and ensure these measures contribute to those adopted for the ministry overall.
19. Establish APP performance measures along a continuum (including patient health outcomes), using a process that is linked directly to the development of program objectives.
20. Establish targets which identify clear expectations of what is to be achieved by the program.
21. Provide greater detail in its service plan and annual service plan report to identify the program and how it contributes to the overall direction of the health system and conduct regular performance and expenditure monitoring at the senior management level.
22. Develop program-level reporting requirements and information systems based on the decision making needs, including those focused on outcomes that are expected to be achieved.
23. Put in place ongoing program evaluation that demonstrates how APP adds value to the provincial health care system.
24. Use the performance management framework that was jointly developed by the Deputy Ministers' Council and our Office to guide efforts in improving the accountability and management effectiveness of APP.

Appendix B: Office of the Auditor General: Risk Auditing Objectives and Methodology

The Office has three lines of business:

- Attesting to the reliability of government financial statements;
- Assessing the quality of government service plan reports;
- Examining how government manages its key risks.

Each of these lines of business have certain objectives that are expected to be achieved, and each employs a particular methodology to reach those objectives. The following is a brief outline of the objectives and methodology applied by the Office for assessing the management of risk within government programs and services, that is, risk auditing.

Risk Auditing

What are Risk Audits?

Risk audits (also known as performance or value-for-money audits) examine whether money is being spent wisely by government—whether value is received for the money spent. Specifically, they look at the organizational and program elements of government performance, whether government is achieving something that needs doing at a reasonable cost, and consider whether government managers are:

- making the best use of public funds; and
- adequately accounting for the prudent and effective management of the resources entrusted to them.

The aim of these audits is to provide the Legislature with independent assessments about whether government programs are implemented and administered economically, efficiently and effectively, and whether Members of the Legislative Assembly and the public are being provided with fair, reliable accountability information with respect to organizational and program performance.

Appendix B: Office of the Auditor General: Risk Auditing Objectives and Methodology

In completing these audits, we collect and analyze information about how resources are managed; that is, how they are acquired and how they are used. We also assess whether legislators and the public have been given an adequate explanation of what has been accomplished with the resources provided to government managers.

Focus of Our Work

A risk audit has been described as:

> *...the independent, objective assessment of the fairness of management's representations on organizational and program performance, or the assessment of management performance, against criteria, reported to a governing body or others with similar responsibilities.*

This definition recognizes that there are two forms of reporting used in risk auditing. The first—referred to as attestation reporting—is the provision of audit opinions as to the fairness of management's publicly reported accountability information on matters of economy, efficiency and effectiveness. This approach has been used to a very limited degree in British Columbia because the organizations we audit do not yet provide comprehensive accountability reports on their organizational and program performance.

We believe that government reporting along with independent audit is the best way of meeting accountability responsibilities. Consequently, we have been encouraging the use of this model in the British Columbia public sector, and will apply it where comprehensive accountability information on performance is made available by management.

As the risk audits conducted in British Columbia use the second form of reporting—direct reporting—the description that follows explains that model.

Our "direct reporting" risk audits are not designed to question whether government policies are appropriate and effective (that is achieve their intended outcomes). Rather, as directed by the Auditor General Act, these audits assess whether the programs implemented to achieve government policies are

being administered economically and efficiently. They also evaluate whether Members of the Legislative Assembly and the public are being provided with appropriate accountability information about government programs.

When undertaking risk audits, we look for information about results to determine whether government organizations and programs actually provide value for money. If they do not, or if we are unable to assess results directly, we then examine management's processes to determine what problems exist or whether the processes are capable of ensuring that value is received for money spent.

Selecting Audits

All of government, including Crown corporations and other government organizations, are included in the universe we consider when selecting audits. We also may undertake reviews of provincial participation in organizations outside of government if they carry on significant government programs and receive substantial provincial funding.

When selecting the audit subjects we will examine, we base our decision on the significance and interest of an area or topic to our primary clients, the Members of the Legislative Assembly and the public. We consider both the significance and risk in our evaluation. We aim to provide fair, independent assessments of the quality of government administration and to identify opportunities to improve the performance of government. Therefore, we do not focus exclusively on areas of high risk or known problems.

We select for audit either programs or functions administered by a specific ministry or government organization, or cross-government programs or functions that apply to many government entities. A large number of such programs and functions exist throughout government. We examine the larger and more significant of these on a cyclical basis.

Our view is that, in the absence of comprehensive accountability information being made available by government, risk audits using the direct reporting approach should be undertaken on a five- to six- year cycle so that Members of the Legislative Assembly and the public receive assessments of all significant government operations over a reasonable time period. We strive to achieve this schedule, but it is affected by the availability of time and resources.

Appendix B: Office of the Auditor General: Risk Auditing Objectives and Methodology

Planning and Conducting Audits

A risk audit comprises four phases—preliminary study, planning, conducting and reporting. The core values of the Office—independence, due care and public trust—are inherent in all aspects of the audit work.

Preliminary Study

Before an audit starts, we undertake a preliminary study to identify issues and gather sufficient information to decide whether an audit is warranted.

At this time, we also determine the audit team. The audit team must be made up of individuals who have the knowledge and competence necessary to carry out the particular audit. In most cases, we use our own professionals, who have training and experience in a variety of fields. As well, we often supplement the knowledge and competence of our staff by engaging one or more consultants to be part of the audit team.

In examining a particular aspect of an organization to audit, auditors can look either at results, to assess whether value for money is actually achieved, or at management's processes, to determine whether those processes should ensure that value is received for money spent. Neither approach alone can answer all the questions of legislators and the public, particularly if problems are found during the audit. We therefore try to combine both approaches wherever we can. However, because acceptable results-oriented information and criteria are often not available, our risk audits frequently concentrate on management's processes for achieving value for money.

If a preliminary study does not lead to an audit, the results of the study may still be reported to the Legislature.

Planning

In the planning phase, the key tasks are to develop audit criteria—"standards of performance"—and an audit plan outlining how the audit team will obtain the information necessary to assess the organization's performance against the criteria. In establishing the criteria, we do not expect theoretical perfection from public sector managers; rather, we reflect what we believe to be the reasonable expectations of legislators and the public.

Appendix B: Office of the Auditor General: Risk Auditing Objectives and Methodology

Conducting

The conducting phase of the audit involves gathering, analyzing and synthesizing information to assess the organization's performance against the audit criteria. We use a variety of techniques to obtain such information, including surveys, and questionnaires, interviews and document reviews.

Reporting Audits

We discuss the draft report with the organization's representatives and consider their comments before the report is formally issued to the Legislative Assembly. In writing the audit report, we ensure that recommendations are significant, practical and specific, but not so specific as to infringe on management's responsibility for managing. The final report is tabled in the Legislative Assembly and referred to the Public Accounts Committee, where it serves as a basis for the Committee's deliberations.

Reports on risk audits are published throughout the year as they are completed, and tabled in the Legislature at the earliest opportunity. We report our audit findings in two parts: an Auditor General's Comments section and a more detailed report. The overall conclusion constitutes the Auditor General's independent assessment of how well the organization has met performance expectations. The more detailed report provides background information and a description of what we found. When appropriate, we also make recommendations as to how the issues identified may be remedied.

It takes time to implement the recommendations that arise from risk audits. Consequently, when management first responds to an audit report, it is often only able to indicate its intention to resolve the matters raised, rather than to describe exactly what it plans to do.

Without further information, however, legislators and the public would not be aware of the nature, extent, and results of management's remedial actions. Therefore, we publish updates of management's responses to the risk audits. In addition, when it is useful to do so, we will conduct follow-up audits. The results of these are also reported to the Legislature.

Appendix C: Office of the Auditor General: 2003/04 Reports Issued to Date

Report 1

A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities

Report 2

Follow-up of Performance Reports, August 2003

Report 3

Adopting Best Practices in Government Financial Statements –2002/2003

Report 4

Alternative Payments to Physicians: A Program in Need of Change

This report and others are available on our website at http://www.bcauditor.com

Compiled and typeset by Graphic Designer, Debbie Lee Sawin, of the Office of the Auditor General of British Columbia
and published by the Queen's Printer for British Columbia©
Victoria 2003